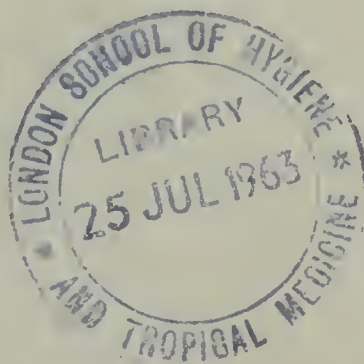


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COUNTY COUNCIL OF ESSEX  
EDUCATION COMMITTEE



ANNUAL REPORT

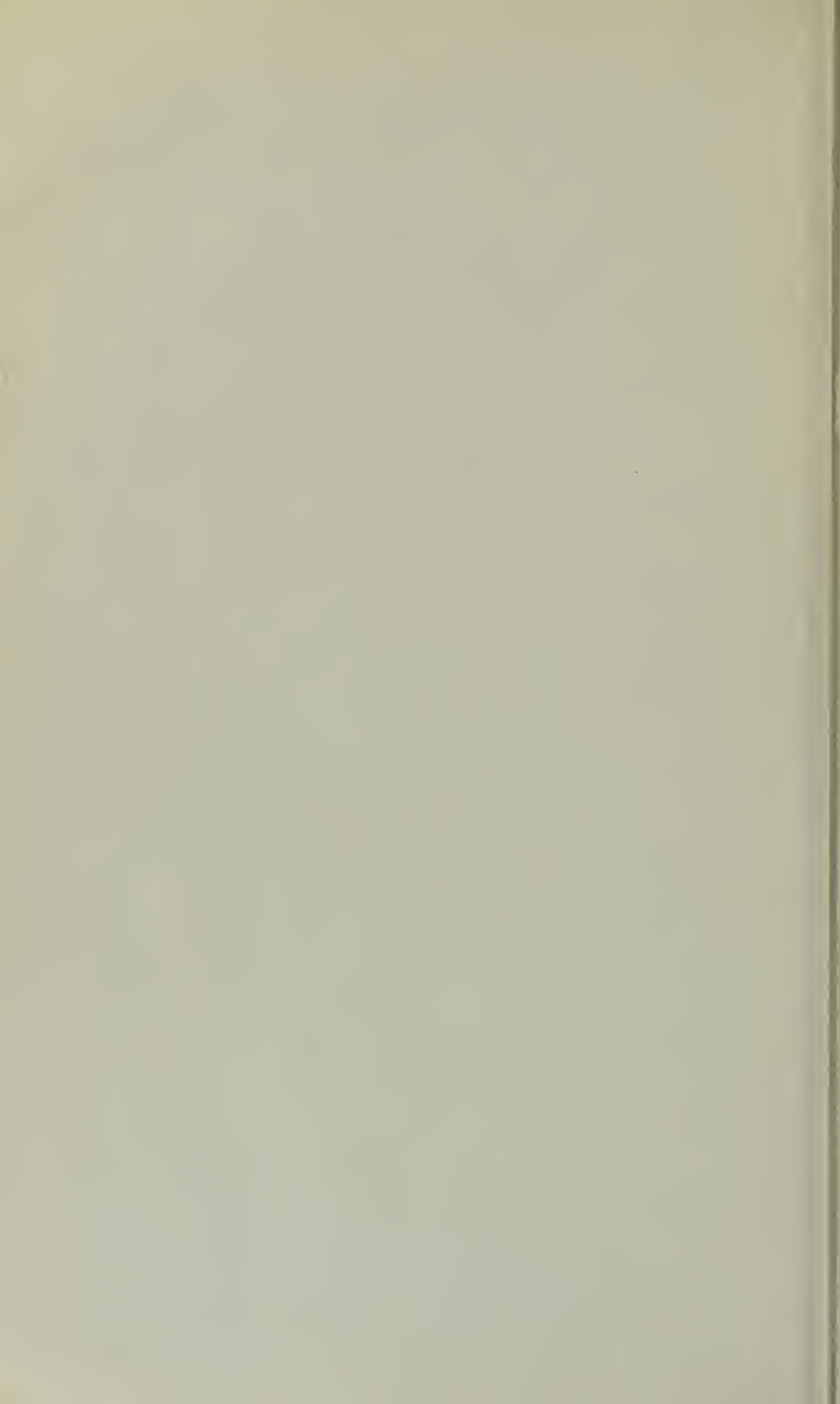
OF THE

Principal School  
Medical Officer

FOR THE YEAR

1956

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COUNTY COUNCIL OF ESSEX  
EDUCATION COMMITTEE



ANNUAL REPORT

OF THE

Principal School  
Medical Officer

FOR THE YEAR

1956

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# THE SPECIAL SERVICES SUB-COMMITTEE OF THE EDUCATION COMMITTEE — 1956

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|                                                   |                           |
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## ANNUAL REPORT OF THE PRINCIPAL SCHOOL MEDICAL OFFICER

## PREFACE

COUNTY HALL,  
CHELMSFORD

*To the Chairman and Members of the Education Committee.*

Sir, Ladies and Gentlemen,

I have the honour to present the Report of the Principal School Medical Officer for the year 1956. Apart from the Report of the Principal School Dental Officer (pages 58-62) I am indebted to Dr. T. K. Whitmore (Senior Medical Officer—Child Health) for the compilation of much of the Report : without adopting the easy-going style which endeavours to interest the man-in-the-street so common in the preparation of Annual Reports in recent years, he has dealt with the subject matter in an informative and readable manner. There is, thus, very little that requires special comment.

I must, however, draw attention to the nature of the sanitary arrangements in some school buildings as revealed in the paragraphs dealing with the subject on page 14 of the Report. That 101 school buildings in the rural parts of the County should still be dependent upon the " bucket " system in the year 1956 is hardly satisfactory.

Another matter to which attention should be given is the rinsing of milk bottles after use at schools and I would commend the note in regard to this on page 15 to the attention of all Head Teachers.

More satisfactory is the progress which has been made in combating tuberculosis in school children (pages 19-22) and diphtheria (page 22). There is every prospect that similar success will be achieved in regard to poliomyelitis (page 22) now that larger quantities of vaccine are becoming available ; in this connection, however, the occasional outbreaks of benign aseptic virus meningitis such as that which occurred at Harlow in 1956 (page 27) give cause for some little concern.

There is much of interest so far as the future development of the school health service is concerned in the section dealing with Ascertainment and Treatment (pages 30-43) and the analyses of the information available in relation to individual defects deserves careful attention, particularly that relating to deafness.

Of particular interest is the account of the work which is being done for blind and partially sighted children at the Joseph Clarke School at Walthamstow (pages 43-46).

Once again I record my grateful thanks for the support which I receive from Members of the Committee and for the continued loyalty and assistance which is afforded by the staff of the Service both in the field and in the Central Office.

I have the honour to be,  
Your obedient Servant,

*Geo. G. Stewart*

*Principal School Medical Officer.*

## STAFF

---

31st December, 1956

---

### CENTRAL OFFICE

*Principal School Medical Officer :*

GEORGE G. STEWART, M.R.C.S., L.R.C.P., D.P.H.

*Deputy Principal School Medical Officer :*

J. A. C. FRANKLIN, M.B., B.S., D.P.H.

*Senior Medical Officer (Child Health) :*

T. K. WHITMORE, M.R.C.S., L.R.C.P., D.C.H.

*Principal School Dental Officer :*

J. BYRON, L.D.S.

m

### DIVISIONAL STAFFS

North-East Essex Educational Division

#### MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*JOHN D. KERSHAW, M.D., B.S., D.P.H.

*School Medical Officers :*

ANN B. CLARK, M.R.C.S., L.R.C.P.

\*R. E. BARRETT, M.B., B.S., M.R.C.S., L.R.C.P., D.T.M. & H., D.P.H.  
(Commenced 1.3.56)

\*E. A. HARGREAVES, M.R.C.S., L.R.C.P., D.P.H.

\*J. R. HETHERINGTON, L.R.C.P. & S., L.R.F.P.S., D.P.H.

SYLVIA I. E. MACMILLAN, M.B., B.S., D.P.H.

\*R. D. PEARCE, M.R.C.S., L.R.C.P., D.P.H.

\*J. S. RANSON, M.R.C.S., L.R.C.P., D.P.H.

ELEANOR M. SINGER, M.Sc., M.R.C.S., L.R.C.P., D.C.H.

In addition there are four Medical Officers undertaking 6 sessions a week on a sessional basis.

#### DENTAL OFFICERS

A. LONGDEN, L.D.S.  
(Commenced 23.7.56)

\*A. W. J. LARKIN, Dentist  
(Commenced Part-time 16.1.56)

\*J. F. GODFREY, L.D.S.

R. A. TRAN, L.D.S.

In addition there are three Dental Officers undertaking 11 sessions a week on a sessional basis.

\* *Part-time Officer*

## Mid-Essex Educational Division

## MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*J. L. MILLER WOOD, M.R.C.S., L.R.C.P., D.P.H.

*School Medical Officers :*

\*T. D. BLOTT, B.Sc., M.B., B.S., D.P.H.

JOYCE W. BROWN, M.B., Ch.B., D.P.H.

DEIDRE R. DOOLEY, L.R.C.P. & S., D.C.H.

I. G. P. FRASER, M.B., Ch.B., D.P.H.

(Commenced 28.5.56)

\*IRENE M. CONWAY HASTILOW, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

D.C.H., D.Obst. R.C.O.G.

MURIEL PARKES, B.A., M.B., B.Ch., B.A.O.

\*C. R. C. RAINSFORD, M.D., D.P.H., D.T.M.

ANNETTE WYATT, M.D., B.S., M.R.C.S., L.R.C.P.

MARGARET TURNER, M.R.C.S., L.R.C.P.

## DENTAL OFFICERS

B. G. BROWN, L.D.S.

MRS. N. S. MEZITS, Dental Doctor, Latvia

\*R. N. ROBSON, L.D.S.

(Commenced 1.10.56)

In addition there are four Dental Officers undertaking 15 sessions a week on a sessional basis.

## South-East Essex Educational Division

## MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*W. J. MOFFAT, M.B., Ch.B., D.P.H.

*School Medical Officers :*

JEAN BUCHANAN, M.B., Ch.B.

J. C. T. FIDDES, M.B., Ch.B.

T. H. J. HARGREAVES, M.R.C.S., L.R.C.P.

\*N. S. R. LORRAINE, M.D., Ch.B., D.P.H.

\*P. X. O'DWYER, M.B., B.Ch., D.P.H.

J. REACH, M.D. (Prague)

JEAN TROUGHTON, L.R.C.P. & S.

## DENTAL OFFICERS

H. J. CRACKNELL, L.D.S.

H. LEVISON, B.D.S., L.D.S.

R. MAXWELL, L.D.S.

\*H. L. THORN, L.D.S.

In addition there are four Dental Officers undertaking 11 sessions per week on a sessional basis.

\* *Part-time Officer*

## South Essex Educational Division

### MEDICAL OFFICERS

#### *Divisional School Medical Officer :*

\*W. T. G. BOUL, M.B.E., M.D., D.P.H., F.Z.S.

#### *School Medical Officers :*

URSULA M. ANDERSON, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

M. J. CATTON, M.B., B.S.  
(Commenced 20.2.56)

ELIZABETH M. HARGREAVES, M.B., Ch.B., D.P.H.

W. R. HOWELL, L.M.S.S.A.  
(Commenced 3.12.56)

R. G. NEWBERRY, M.B., B.S.  
(Commenced 1.4.56)

MARY M. E. RUTTER, M.R.C.S., L.R.C.P., M.B., B.S., D.C.H., M.D., D.P.H.

ANIELA A. SZWEDE, M.B., Ch.B.

DORIS C. E. WALKER, M.B., B.S., L.R.C.P., M.R.C.S., D.A.

\*S. R. WARREN, M.B., Ch.B., D.P.H.

MAIR E. WILLIAMS, M.R.C.S., L.R.C.P.

### DENTAL OFFICERS

R. A. COLLINS, L.D.S.

MRS. C. GRIESHABER, Doctor Medicinal Dentium, Berlin University

MRS. O. SAUNDERS, Diploma of Dental Surgery, Latvia

In addition there are four Dental Officers undertaking 13 sessions a week on a sessional basis.

## Forest Educational Division

### MEDICAL OFFICERS

#### *Divisional School Medical Officer :*

\*F. G. BROWN, T.D., M.B., B.Ch., B.A.O., D.P.H.

#### *School Medical Officers :*

\*I. ASH, M.D. (Rome), D.P.H.  
(Commenced 13.2.56)

\*J. H. CROSBY, M.B., Ch.B., D.P.H.

GISSELLA EISNER, M.D. (Prague), D.C.H.

E. L. EWAN, M.B., Ch.B., B.Hy., D.P.H.

\*H. FRANKS, M.B., B.S., B.Hy., D.P.H.

LILY WHITE, M.B., Ch.B.  
(Commenced 3.4.56)

In addition there are two Medical Officers undertaking 5 sessions a week on a sessional basis.

### DENTAL OFFICERS

MRS. L. E. BROADBENT, L.D.S.

MRS. E. KIMELMAN, M.D. (Vienna)

C. S. NEAME, L.D.S.

In addition there are four Dental Officers undertaking 14 sessions a week on a sessional basis.

\* *Part-time Officer*

Romford Educational Division  
MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*JAMES B. SAMSON, M.D., Ch.B., D.P.H.

*School Medical Officers :*

J. J. DUFFY, M.B., B.Ch., B.A.O., D.P.H.

ELIZABETH M. HAGA, M.B., B.S., L.R.C.P., M.R.C.S., D.P.H.

SYLVIA R. INGOLD, M.B., B.S., M.R.C.S., L.R.C.P., D.Obst. R.C.O.G.  
(Commenced 16.1.56)

N. P. BHANDARI, M.B., B.S., L.R.C.P., M.R.C.S., C.P.H.  
(Commenced 15.10.56)

DENTAL OFFICERS

MISS M. L. ELL, L.D.S.

MRS. D. SHIRLAW, L.D.S.

In addition there are 3 Dental Officers undertaking 7 sessions a week on a sessional basis.

Barking Educational Division  
MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*F. L. GROARKE, M.B., L.M., D.C.H., D.P.H.

*School Medical Officers :*

\*MARGARET I. ADAMSON, M.B., Ch.B., D.P.H.

EILEEN E. MARTIN, M.B., Ch.B.

EUGENIA POPPER, M.D. (Vienna)

A. E. SELIGMANN, M.D. (Leipzig), D.T.M. & H.

VIOLET SPILLER, M.D. (Geneva), M.R.C.S., L.R.C.P., D.P.H.

MARY H. WESTLAKE, M.B., Ch.B., D.P.H.

DENTAL OFFICERS

A. R. LEVY, L.D.S.

J. BUNTIN, L.D.S.

In addition there are two Dental Officers undertaking 7 sessions a week on a sessional basis.

Dagenham Educational Division  
MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*J. ADRIAN GILLET, M.B., Ch.B., D.P.H.

\* *Part-time Officer*

*School Medical Officers :*

CATHERINE FITZPATRICK, M.B., B.Ch.  
 FANNIE HIRST, M.B., Ch.B., D.P.H.  
 E. P. JAMES, M.R.C.S., L.R.C.P., L.M.S.S.A., D.Obst.R.C.O.G.  
 (Commenced 2.1.56)  
 WILHELMINA C. MAGUIRE, L.M., L.R.C.P., L.R.C.S.I.  
 \*HELEN E. MAIR, M.B., Ch.B., D.P.H.  
 (Commenced 16.1.56)  
 MADELINE WEIZMANN, M.R.C.S., L.R.C.P.

In addition there is one Medical Officer undertaking 1 session each week on a sessional basis.

**DENTAL OFFICERS**

There are three Dental Officers undertaking 8 sessions a week on a sessional basis.

**Ilford Educational Division****MEDICAL OFFICERS***Divisional School Medical Officer :*

\*I. GORDON, M.D., Ch.B., M.R.C.P., D.P.H.

*School Medical Officers :*

ANNIE COLLINS, M.B., B.Ch., B.A.O.  
 FRANCES E. O'CONNOR-WILSON, B.A., M.B., B.Ch., B.A.O., D.P.H., L.M.  
 HELEN B. GRANGE, M.B., B.S.  
 \*DESIREE M. B. GROSS, M.D., Ch.B., M.M.S.A., D.P.H.  
 \*JOAN M. POOLEY, M.B., B.S., D.C.H.  
 R. M. NOORDIN, M.R.C.S., L.R.C.P.

**DENTAL OFFICERS***Senior Dental Officer :*

E. V. HAIGH, L.D.S.

In addition there are nine Dental Officers undertaking 26 sessions a week on a sessional basis.

**Leyton Educational Division****MEDICAL OFFICERS***Divisional School Medical Officer :*

\*M. WATKINS, M.R.C.S., L.R.C.P., D.P.H.

*School Medical Officers :*

ETHEL R. EMSLIE, M.D., Ch.B., D.P.H., D.C.H.  
 \*MARY L. GILCHRIST, M.D., Ch.B., D.P.H.  
 T. MACKINNELL-CHILDS, B.A., M.B., B.Ch., M.R.C.S., L.R.C.P., D.P.H.  
 (Commenced 1.8.56)  
 ELSIE L. PEET, M.D., M.B., L.D.S.

In addition there is one Medical Officer undertaking 1 session a week on a sessional basis.

\* *Part-time Officer*

## DENTAL OFFICERS

*Senior Dental Officer :*

A. E. HALL, L.D.S.

In addition there are eight Dental Officers undertaking 25 sessions a week on a sessional basis.

## Walthamstow Educational Division

## MEDICAL OFFICERS

*Divisional School Medical Officer :*

\*A. T. W. POWELL, M.C., M.B., B.S., D.P.H.

*School Medical Officers :*

\*MARGARET EDWARDS, M.B., B.Ch., C.P.H.  
(Commenced 23.4.56)

\*GEOFFREY POOLE., M.B., B.S., D.Obst.R.C.O.G., D.P.H.

CARMEL P. DOOLEY, L.R.C.P. and S., D.P.H.  
(Commenced 1.6.56)

\*JOYCELYN, H. NEWMAN, M.B., Ch.B., D.Obst.R.C.O.G., D.P.H.

JOSEPHINE P. WERREN, M.B., B.S., M.R.C.S., L.R.C.P., D.C.H., D.Obst.R.C.O.G.  
(Commenced 3.4.56)

## DENTAL OFFICERS

*Senior Dental Officer :*

L. W. ELMER, L.D.S.  
(Retired 31.12.56)

*Dental Officers:*

MISS D. ANKLESARIA, L.D.S.

R. E. HYMAN, L.D.S.

P. PEARCE, B.D.S.

G. P. L. TAYLOR, L.D.S.

J. TIMMIS, L.D.S.

In addition there is one Dental Officer undertaking 3 sessions a week on a sessional basis.

\* *Part-time Officer*

## SCHOOL NURSING STAFF AND DENTAL ATTENDANTS

|                              |                                                                                                               |
|------------------------------|---------------------------------------------------------------------------------------------------------------|
|                              | <i>Aggregate of time<br/>given to School<br/>Health Service work<br/>in terms of whole-<br/>time officers</i> |
| Health Visitor/School Nurses | 187 } 95.56                                                                                                   |
| School Nurses only           | 48 }                                                                                                          |
| Nursing Assistants           | 35    15.63                                                                                                   |
| Dental Attendants            | 57    42.69                                                                                                   |

**COUNTY COUNCIL OF ESSEX EDUCATION COMMITTEE**

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**ANNUAL REPORT**  
of the  
**PRINCIPAL SCHOOL MEDICAL OFFICER**  
for the year 1956

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**A. ASSESSMENT OF HEALTH****1. School Population**

The school population again increased during 1956 and at the end of the year there were 270,295 pupils on school rolls, 8,675 more than a year ago. However, the rate of increase is still steadily diminishing from the peak of 12,963 additional pupils in 1952. This is to be expected because the birthrate in Essex, following the national pattern, has fallen from a post war peak of 20.6 per thousand population in 1947 to a steady level of approximately 14.5 since 1950.

The increased number of children who entered school between 1951 and 1954 is now in process of moving from primary to secondary schools which accounts for the continuing increase in the number of secondary school pupils as compared with the primary school pupils, a trend which first appeared a year ago.

That the rate of increase in the total school population does not fall more rapidly is mainly due to the influx of children from other areas. It is estimated that over 6,000 children of school age moved into Essex during 1956 ; almost half of them to the South East Essex and Forest Divisions where the new towns of Basildon and Harlow are developing. In addition the steady development in private house building, particularly near London, gives rise to problems in connection with the planning of new school buildings and the provision of school health services.

**2. Medical Inspection**

In 1953 the Ministry of Education issued revised regulations which introduced certain changes in the requirements regarding medical inspections. Instead of the three general medical inspections formerly prescribed at specific periods it is now only necessary to ensure a minimum of three inspections during a child's school life, the timing of the inspections being a matter of discretion. Additional inspections may be arranged if this is considered to be desirable and provision is made for the approval of arrangements for fewer inspections where it is desired to experiment with arrangements not based on periodic medical inspections.

Three routine periodic medical inspections continue to be the standard practice in Essex except in Barking where five inspections are undertaken including three intermediate inspections at 7 years, 9 years and 11 years, and where grammar school pupils are given a sixth inspection on leaving.

During 1956, 77,180 routine periodic medical inspections were carried out in the county compared with 76,335 in 1955. More than half these examinations were of children aged 10-12 years, consequent upon the move into secondary schools referred to above.

There were fewer special and follow-up inspections during 1956 and for the first time for a number of years they were less than the number of routine inspections. The number of follow-up examinations was only three-quarters of the number four years ago. The number of first special inspections has again increased due to the fact that children with possible defects are now referred to the School Medical Officer as early as possible.

It would appear to be a natural sequel of this trend to consider substituting arrangements which would allow more facilities for special inspections and consultations between the school staff and parents for the intermediate routine medical inspection and this is probably what the Minister had in mind when framing the new Regulations referred to earlier. Very few authorities have availed themselves of this discretion although there has been much discussion about it. It cannot be denied that a general medical examination of school entrants and school leavers is an excellent and necessary procedure but it is open to question whether similar periodic overhauls during the intervening school years are either necessary or effective or show sufficient return for the number of doctor-hours involved. Experience has shown that although parents, teachers and nurses can give invaluable help it is not desirable that they should have the sole responsibility of selecting children with possible defects. Any alternative to routine periodic medical inspections must therefore provide for closer contact between the School Medical Officer and the school. This would also incidentally allow the School Medical Officer to become the school doctor, a recognised member of the school staff and counsellor to the head teacher on all matters concerning the collective and individual mental and physical health of the children.

Dr. John D. Kershaw (North East Essex) discusses this point in his report and, referring to his experience before coming to the North East Essex Division states :—

“ My own experience confirms that of others who have tried it (the abolition of the intermediate inspection) namely, that in favourable circumstances it can be done not merely without harm resulting but with an eventual improvement in results. The ‘ favourable circumstances ’ are briefly the following :—

The head teacher and staff must be actively interested and co-operative.

The school nurse must be in close and regular touch with the school.

The school medical officer must have the complete confidence of the staff and must visit the school regularly and frequently”.

It is hoped that a limited experiment on these lines may be possible next year in a few selected schools in Colchester.

### **3. Physical fitness of school children**

Reference was made in 1955 to the alteration made in connection with the classification of the physical condition of school children at routine medical inspections. From the beginning of the year under review a revised school medical record card was introduced and it is now only necessary for School Medical Officers to consider whether a child's physical fitness is “satisfactory” or “unsatisfactory,” the criterion being that if there is any condition requiring investigation or treatment the child's physical fitness should be considered unsatisfactory.

The findings of School Medical Officers at routine medical examinations are detailed in Table I D (Appendix A page 63). No comparison can be made with the results of previous years as a different classification was in use. It is, however, possible to record that the physical fitness of 3% of children seen at the entrants and intermediate medical inspections was unsatisfactory, whilst that of 99% of school leavers was satisfactory. It will be seen also that the physical fitness of 5.4% of children of all ages examined at additional inspections was unsatisfactory which is probably accounted for by the fact that the children seen at these additional inspections included all the pupils at special schools.

## **B. PROMOTION OF HEALTH**

### **4. School Premises**

Twenty primary schools and seven secondary schools were opened during the year and the totals at the end of the year were 699 and 186 respectively. In addition a day special school for educationally sub-normal children at Corbets Tey, Upminster and a residential special school for maladjusted children near Colchester were opened.

During the last few years the Committee have adopted the principle of self-contained classrooms for young children in new primary schools. Each class has its own space for project work and practical activities and also its own sanitary annexe, including cloak-room space, toilets and wash hand basins. This has enabled staff to supervise to a greater extent the personal hygiene of the children and has provided further opportunities for health education.

In addition to special inspections as necessary, the School Medical Officer is responsible for carrying out an inspection of school premises annually including the kitchen, where there is one, or alternatively the arrangements for the serving of school meals. Furthermore, reports are also submitted from time to time by public health inspectors of County District Councils

**SANITATION**—As a result it has been found that very few adverse hygiene reports were made in respect of schools in the urban Divisions, and that whilst with few exceptions the older schools are not provided with sanitary conveniences on such a generous scale as that recommended in “The Standards for School Premises Regulations 1954,” the facilities approximate to those standards. Additional facilities have been recommended and except where the school has been scheduled for closure these have been included in schemes for general improvement.

In the rural Divisions conditions are less satisfactory. Improvement depends largely upon the existence of adequate public sewerage to which the school building can be connected. At the present time 58 of the 201 school buildings in the rural parts of the Divisions adjacent to London are so connected ; 22 having been dealt with during the last ten years. Schemes which include the connection of the village school building have been submitted to the County Council covering another 33 such buildings, and schemes which have been proposed but not yet prepared in detail include provision for yet another 35.

In the 143 school buildings not yet connected to a main sewerage system, the arrangements are as follows :—

|                                                        |      |      |      |      |      |     |
|--------------------------------------------------------|------|------|------|------|------|-----|
| Buckets                                                | .... | .... | .... | .... | .... | 101 |
| Chemical closets                                       | .... | .... | .... | .... | .... | 9   |
| The Hampshire system (a modified type of privy closet) | .... | .... | .... | .... | .... | 8   |
| Cesspits and septic tanks                              | .... | .... | .... | .... | .... | 25  |

Improvements to the sanitary arrangements in 42 school buildings were approved as minor capital projects during the three years 1954 to 1957 but have not yet been completed. Improvements in another twelve schools have been proposed as similar projects for the year 1957/58.

**APLUTIONS**—In most school buildings roller towels are provided for use in the cloakrooms. During the year experiments have been carried out in a number of schools with paper towels and continuous linen towelling supplied in special cabinets. It has been found that young children using these cabinets often need to be reminded to pull the towel before drying the hands but generally speaking the advantages of the system have been found to be such that the Committee have decided to provide towelling cabinets in all new school buildings. It is expected also that they will be installed in many schools in which up to the present time roller towels have been used.

**DRINKING FOUNTAINS**—Another matter which has received attention, and which is still under consideration, is the provision of the most suitable type of drinking fountain bearing in mind the desirability of preventing children from bringing their lips into direct contact with the nozzle.

## 5. School Meals Service

At the end of 1956 the number of children having dinner at school was 126,708. This is slightly more than last year but the increase has not kept pace

with the increase in school population. The percentage was 55 compared with 62 in 1946.

The rising prices of food, the increased cost of overheads resulting from higher wages and fuel costs, and the new rating assessments on school premises made it necessary to increase the price of the meal to 10d. during the year but the high quality of the meals has been maintained and greater variety has been introduced.

Although one-third of a pint of milk per child at school is provided free of cost, the acceptance rate in 1956 was only 84 % as compared with 90 % in 1947. Attention should be given to this matter with a view to undertaking further propaganda amongst parents and children on the nutritive value of milk.

During the year the supply of free milk was curtailed by the Minister of Education to the extent that it is now available only during term time and on days when schools are open for instruction.

From time to time complaints are received from milk distributors regarding the condition of empty milk bottles returned to them from schools. They refer specifically to the stale milk which dries hard on the bottom and in the neck of the bottles when they are not rinsed out after use and to bottles being often returned without the caps and straws having been removed. Dairies have considerable difficulty in cleaning such bottles even when the most efficient machines are used and staff has to be specially employed in removing the caps and straws. To permit of bottles being returned in the state complained of is a very indifferent object lesson to the children and misses an opportunity for an excellent exercise in health education. It must be said that in many schools the children do rinse their bottles and remove the caps and straws and their example must be followed. There is no school building which lacks a waste box for caps and straws and in the newer buildings, where each classroom is often supplied with a sink, (and even in the older types of building there is a supply of water conveniently placed for the purpose), pupils should be encouraged to rinse out the milk bottles after use, despite the risk of accidents.

Unfortunately, because the Ministry of Education had to reduce expenditure, the hopes raised by last year's increase in the amount of money allocated to major and minor capital projects did not fully materialise and only a few kitchens and dining halls were built in existing schools although a substantial programme of work had been arranged and was ready to go ahead.

**SCHOOL CANTEENS**—The Food Hygiene Regulations 1955 came into operation on the 1st January, 1956. Of special interest in connection with the school meals service are those relating to :—

Personal cleanliness of kitchen staff (Regulation 9).

Sanitary conveniences (Regulation 14).

The provision of wash hand basins (Regulation 16).

Facilities for washing food and equipment (Regulation 19).

The keeping of certain foods at specified temperatures (Regulation 25).

During the year many existing kitchens and canteens, mostly in buildings which were brought into use during the war, were brought up to the standards required by the Regulations.

In new school buildings suitable provision is being made to conform with all the Regulations.

## 6. Physical Education

The following report by the Senior Organisers of Physical Education has been supplied by the Chief Education Officer :—

*“ Staff.* The establishment of Organisers of Physical Education responsible for the administration of physical education consists of five women and four men, two of whom are senior organisers. Each of the divisions of the County has part-time use of one man and one woman organiser who work in two or three divisions according to the population or area to be covered. The senior organisers, working from the central office, are available for consultations with other departments, and co-ordinate the work of the area organisers as well as being responsible for three divisions. In addition to their work of advising and demonstrating in schools, they have visited Youth Centres and Evening Institutes, etc., in order to encourage the continuation of physical education when children have left school. Probably the most important aspect of their work is the training of teachers, which was carried on throughout the year. Courses, demonstrations, etc., well attended and appreciated, were held in many parts of the County, and the work in the schools testified to their value. An interesting innovation was the staging of four demonstrations at the County Show. Despite difficulties of space and uneven grass surface, they were very successful ; the dancing and trampoline especially provided spectacular events.

There is still a shortage of specialist physical education teachers not only in the County, but in the country as a whole. The Ministry of Education recognising this, has instituted more one-year post certificate graduate courses in various widely dispersed colleges. The effect of these courses has not yet been felt, but it is hoped that within a very few years all the boys and girls, and indeed adults, using our gymnasias and playing fields will be taught by fully qualified teachers.

*Games and Athletics, etc.* Except in parts of Metropolitan Essex, where children have to be transported, the County is well provided with playing fields, most of them within easy reach of the school. This easy access of fields has had and still has a great deal of influence in the fact that Essex teams competing nationally are amongst the leading county teams. These teams, selected after divisional sports and trials, are the

result of careful coaching by the teachers, who deserve the best congratulations. The major games—football, cricket, rounders, hockey, netball, tennis—continued to hold the interest of the majority of the children, though it was interesting to note that several secondary modern schools played Rugby football and with some success.

Camping sites and canvas were available and many schools took advantage of them. As part of their metal and woodwork training, schools built their own boats and sailing was an established activity. The new school at Dovercourt was equipped with a special room, with apparatus, enabling larger boats to be constructed. Thus the wider aspects of physical education, as well as the more traditional, were catered for.

*Dance.* The type of dance taught in the schools still varied according to the training and interest of the teacher. The usual type is English Country and National Dancing. The Physical Education Organisers encourage the teaching of dancing to boys and girls in mixed groups, not only for the controlled movement it produces but for the easy relationship between the sexes which is the result of dancing together. Experience has shown that the general tone of behaviour improves tremendously where national and country dancing is included for every class. There has been a great increase in the number of boys taking part in the Dance Parties and Festivals which were held in many areas, both indoors and out and the tendency to think of dancing as a subject only suitable for girls is rapidly dying.

*Swimming.* Last December a very fine closed swimming bath was opened in Hornchurch and this now caters for approximately 500 children daily, a very large proportion of whom are non-swimmers. In accordance with the general policy, a full-time swimming instructor has been appointed and parties of children are transported to the baths from all the schools in the district.

The L.C.C. Residential school at Hutton has an indoor swimming bath and Essex children now use this on four days a week and in the summer of 1957 parties from schools in South-East Essex are to visit the open-air pool at Battlesbridge for the first time.

There are, however, still many areas where there are no facilities for teaching swimming. Most of the instructional swimming baths planned to be built in the larger schools have had to be omitted at present owing to the necessity for economy, but it is hoped they will be reinstated in future plans. More closed baths are necessary, and encouragement and support for the building of both council and individual school baths is important.

No opportunity has been lost, however, of making full use of those baths that are available. The more advanced swimmers are encouraged

and helped by the activities of the Essex County Schools Swimming Association. Through this Association children compete in a County Gala, an Eastern Counties Divisional Gala, and finally a National Gala. Special coaching sessions are also arranged at the South-East Essex Technical College for promising swimmers and divers and these are conducted by the Olympic Coach, Mr. C. Laxton. There is also a County scheme for awarding certificates to swimmers at all stages, from swimming 25 yards to passing advanced tests in style, speed and endurance. During the year hundreds of these certificates were awarded.

*Gymnastics.* A general training in basic movement where the children express certain qualities such as speed and strength, is very much on the increase. This training was introduced into the country by Mr. R. Leban and teachers are trained at the Art of Movement Studio in Surrey. Many Colleges have incorporated the method in their physical education training and Essex Organisers arranged lectures and refresher courses to allow teachers, who were interested, to continue to study it.

Some teachers have already introduced the understanding of movement qualities to secondary girls' gymnastics and this method was also used with infant and junior classes. Ease and grace of movement, understanding how limbs and bodies can be used, and bodily control were very much improved when the children were taught in this way. The method is in the experimental stage at present and it has yet to be proved that it can give sufficient training in carriage and poise. It can be applied to lessons in dancing as well as gymnastics and sometimes to other subjects, such as games, swimming, etc.

The use of fixed and portable apparatus still plays a big part in gymnastics at all stages.

*Facilities.* Almost every secondary school is provided with fixed gymnastic apparatus. The newer schools have modern gymnasiums, shower baths and dressing rooms, whilst the older ones have apparatus fixed in the hall. The latest "Essex" gymnasium partly erected during the year, will soon be opened. Planned by the organisers, this building caters simultaneously for athletes, games players and gymnasts, having a jumping pit and a trampoline pit under the floor, and easily erected cricket nets. Infant and Junior Schools are now nearly all equipped with apparatus for jumping, climbing, swinging, hanging, etc., on which children are encouraged to experiment and devise activities. This lays a foundation of fearlessness and strength in the younger children and prepares them for a higher degree of skill in the secondary school. Some climbing apparatus has been erected on school playgrounds or fields thus enabling up-to-date teaching methods to be used out of doors as well as inside. Although the methods may change, the main object

of the gymnastic lesson remains unaltered in that it aims to produce a supple body with easy controlled movement and a good carriage, and to develop strength, courage and stamina.

*Clothing.* A wide selection of shoes and clothes is available and by means of a capitation allowance schools buy their own styles, colour, etc. The changing of clothes for physical exercise followed by shower baths, plays a very vital part in the health training of the children. It was noticed that where the habit was formed in the schools, it was carried over into the Youth Centre. The help given by the Medical Officers in talking to parents about the value of these habits has been much appreciated."

**BOXING.** Although boxing is a controversial sport, it is taught wherever there is a capable teacher, and championships are competed for with great enthusiasm. They are conducted under the rules of the Amateur Boxing Association—two of which are of particular interest from a medical point of view as follows :—

Rule 17(a)—A qualified Medical Officer must be in attendance at all tournaments to examine intending competitors. No competitor shall be permitted to box unless certified by the Medical Officer as being fit to do so. It is advisable for a Medical Officer to be in attendance throughout the tournament.

Rule 17(b)—Any boxer who has been debarred from boxing by his Association on medical grounds shall not compete until passed as fit to do so by a Medical Officer nominated by that Association.

Requests are made to Divisional School Medical Officers from time to time to provide the services of a School Medical Officer at tournaments and it has been decided that School Medical Officers should be encouraged to volunteer for such duties as an extension of their work in schools. A panel has been compiled giving individual names and addresses of those Medical Officers who volunteer giving details of the areas in which they are prepared to officiate. Whilst the onus of providing a doctor rests with the sponsors of the tournament, Divisional Education Officers have been told that Divisional School Medical Officers will endeavour to arrange for a School Medical Officer to be in attendance if no alternative arrangement has been made.

## **7. Prevention of Tuberculosis**

The number of school children aged 5-9 years notified in 1956 as having tuberculosis reached a new low level of 33. This represents a 60% reduction on the 1950 notifications. The number of notifications in each of the other two age ranges (10-14 years and 15-19 years) was slightly more than for the previous

year, although since 1950 the general trend in these age ranges has also been downward, as the graph below demonstrates.



It is clear that the incidence of tuberculosis is declining but no false sense of security should be established by favourable mortality and morbidity statistics, because these tend to obscure the fact that tuberculosis in children is still relatively common. For instance, whilst only 73 school children in Essex were notified during the year with two deaths, it should be noted that probably some 3,000 school children, between the ages of 13 and 14 years in the country as a whole have at some time been infected. (See table 1(b) Appendix B, page 71).

Of particular importance in this connection is a scheme at present being carried out in the Forest Division whereby young and susceptible children are tested for evidence of infection with a view to discovering the person from whom they may have become infected. The 5 years age group has been chosen for participation in this scheme because the school entry examination offers a ready-made opportunity of testing them and because prior to their entry to

school, their contacts are limited and therefore the field of search for the source of infection is narrowed. In referring to this scheme, Dr. F. G. Brown reports :—

“ In 1954 and 1955, the method used was to apply a ‘ jelly patch ’ to the child’s back and remove the patch two days afterwards so that the result could be ‘ read ’ by the School Medical Officer. I mentioned in my report for last year that the findings were not dramatic, less than 1 % of the pupils giving a positive reaction. However, after consultation with the Chest Physicians it was considered that the investigation was well worth while and that it should be continued in another form.

Therefore, in 1956, it was decided to carry out a ‘ pilot ’ scheme during the Autumn term only, by selecting one infant school in each district. The method of application was by mantoux (skin) testing as many children as possible, using the Heaf multiple puncture apparatus and reading the results 72 hours later. As this method involves an injection into the child’s arm, it was necessary to obtain the written consent of the parent, before the child was included in the test. The purpose of the scheme was explained to the parents in a letter sent to them with the consent form.

The six schools selected are named below with the percentage of consents against each school :—

|                                          | %     |
|------------------------------------------|-------|
| Chigwell U.D.—Grange Hill C.P. ....      | 57.30 |
| Hereward C.P. Loughton....               | 62.50 |
| Chingford Borough—Yardley Lane C.P. .... | 75.75 |
| Epping U.—Epping C.P. ....               | 56.21 |
| Harlow U.D.—Netteswell C.E. ....         | 67.72 |
| Wanstead & Woodford—Oakdale C.P. ....    | 83.78 |

The invitation to participate was offered to the parents of 655 children, of whom 434 (66.26 %) accepted. This, I consider satisfactory.

Of the 434 children tested, seven (1.61 %) gave a positive reaction to the skin test but of these, three were already known to the Chest Physicians and did not need further investigation. Three of the remaining four were screened at the Chest Clinic and one boy, aged five, was admitted to hospital for further investigation, but the reports on all four were negative, and in the case of three, the family contacts were found to be normal, save in the case of one parent who refused to be examined.

In view of the value of the scheme and the fact that it can be conducted with the minimum of time and expense, it will be continued in 1957 on a wider scale. The parents of all infant children who are due to have their first routine medical inspection at school will be invited to give their consent for their child to participate in the scheme.”

When a case of tuberculosis in either school children or staff is notified, a comprehensive search is made for the source of infection by tuberculin surveys and x-ray examinations amongst contacts. During 1956 eight notifications were received : one each in North East Essex and Dagenham and three each in the Mid-Essex and Forest Divisions. A further survey was made in the Mid-Essex Division when it was found that 75 % of the 13-14 years old children in a school were tuberculin positive prior to B.C.G. vaccination.

## 8. Vaccination against Poliomyelitis

Early in 1956 the Ministry of Health announced that a vaccine had become available which would confer some measure of protection against poliomyelitis and which it was believed could be used safely. Local Health Authorities were invited to offer vaccination on a voluntary basis to all children born between the years 1947 and 1954, whether attending a private or Local Authority school. The number of school children in Essex born between the years mentioned was 129,874 of whom 55,915 children were registered for vaccination.

Only a limited amount of vaccine was available for release and it was therefore impossible to vaccinate all the children who had been registered. Certain age groups based on month of birth were therefore selected for actual vaccination and these were specified by the Minister of Health as each batch of vaccine was released ; vaccination was actually confined to those children born during the months of May and November of the years mentioned above. Full vaccination consists of two injections at intervals of not less than three weeks and 4,339 children had completed the full course of injections by the end of June, when the poliomyelitis season is deemed to begin and vaccination had to cease. Any child whose course of injections was thus interrupted was given priority when vaccination was resumed at the end of November.

The number of children who had poliomyelitis during 1956 is given below for the two age ranges covering most of the school years. Two deaths occurred in these age ranges.

|               | 5—9 yrs. | 10—14 yrs. |
|---------------|----------|------------|
| Non-paralytic | 18       | 9          |
| Paralytic     | 14       | 3          |
| Totals        | 32       | 12         |

## 9. Immunisation against Diphtheria

The number of " booster " immunising injections increased by over 25% during 1956 to 17,234.

DIPHTHERIA : Notified cases of diphtheria in school children numbered only two during 1956. For the eighth year in succession no deaths occurred from this infection.

## 10. Prevention of Intestinal Infection in Schools

A Ministry of Education Circular issued in January, 1954, asked Local Authorities to review the measures they were taking to prevent the occurrence of food poisoning in schools and gave some guidance on the subject. Most of the suggestions mentioned in the circular were found to be the standard practice already in the County, but opportunity was taken to review the arrangements which now include :—

The completion of a medical history questionnaire by all new employees in the School Meals Service.

The medical examination of whole-time canteen staff on first appointment.

An undertaking by all employees that they will, whenever necessary, undergo a medical examination which will include the submission of nasal and throat swabs and specimens of body wastes and blood.

The wearing of suitable head covering.

The issue in pamphlet form of instructions indicating the ways in which food-borne infection is spread, and detailing individual responsibility of canteen staffs in preventing such infection.

The maintenance of close liaison between the School Medical Officer, the School Canteen Organiser and the Head Teacher.

A simple summary of the main points of the Food Hygiene Regulations, 1955, so far as they affect the staff, is handed to each employee and is posted in each kitchen or canteen together with a poster advising the staff of the School Meals Service how they can help to prevent the spread of infection.

Instructions have been issued from time to time regarding the danger of re-heating food which has been partially cooked on the previous day. The importance of this is again emphasized by another outbreak of food poisoning at Walthamstow recently due to infected food. A number of outbreaks in schools during the last three years have been caused in this way, the infecting organism being *Cl. welchii*. When meat is cooked in large joints, it is difficult to ensure that the centre of the joints is adequately heated and it is thought that the organism, which is resistant to moderate heat, survives and multiplies when the meat is allowed to cool prior to re-heating. It was the probable source of infection in the outbreak mentioned above in regard to which Dr. A. T. W. Powell writes :—

“ On Friday morning May 4th, the Headmaster reported that 12 children had been sent home on account of feeling unwell and 18 were absent for reasons unknown.

As many as possible of those absentees were visited by the Medical, School Nursing and Sanitary staffs of the Department, specimens were taken and enquiries made at the adjoining modern school kitchen and dining room.

All the cases were apparently associated with the second sitting and none from the first sitting, nor from the same meal sent out to the adjoining infants department and St. George's R.C. School.

The enquiries at the school kitchen revealed that a female worker had recently been unwell and that a male porter suffered from cracked hands following from his employment. The specimens from the former were later reported to be negative, but the man with cracked hands revealed the presence of faecal streptococci and he was put off work.

The visits paid to the absentees revealed that abdominal pains started on the afternoon of the previous day with diarrhoea during the night and a quick recovery the following day.

The suspected meal on the Thursday consisted of boiled boned mutton with gravy and vegetables, Bakewell tart with custard. This meat had been delivered the previous day, placed in the refrigerator overnight, and cooked on Thursday morning.

In accordance with the usual practice, the sample meal which is always retained, was sent for examination together with 35 other specimens from patients, i.e. 3 adults and 32 children. The outbreak proved to be due to a bacterium known as *Cl. welchii*. The bacteriological examinations were carried out at the Central Public Health Laboratory, Colindale, and Dr. Betty Hobbs was good enough to visit Walthamstow for a full discussion including a visit to the school kitchen. Dr. Hobbs emphasized that the essential measure necessary was to cut down as far as possible the interval between cooking and consumption. The great difficulty is the time taken to carve meat for say, up to 300 people. The meat is placed in covered containers on a hotplate but unfortunately the temperature maintained in these containers is not sufficiently high to prevent the growth of this particular bacterium. Certain suggestions were made, including the retention of the gravy at near boiling point and its addition to the meat at the last possible moment, but Dr. Hobbs proposed to visit the Chapel End kitchen to carry out further investigations."

Subsequently Dr. Betty Hobbs of the Public Health Laboratory, Colindale, supplied the following report upon investigations :—

" The effect of different storage temperatures on germination of the spores and the multiplication of the bacillary forms of *Cl. welchii* inoculated on to slices of freshly boiled lamb and into gravy was investigated in the Chapel End kitchen.

Legs of lamb boiled on the morning of the experiment were sliced automatically at about 10.30 a.m. Three slices were placed into each of four tins and each slice was inoculated with approximately 10,000—16,000 viable spores (two experiments), or approximately 260,000

viable organisms including bacilli and spores (one experiment). The tins were left in the hot-plate, on top of the hot-plate, with and without gravy, and at room temperatures. The three slices were removed at hourly intervals and stored in the cold pending examination ; temperatures were recorded at the same time ; control slices of inoculated and uninoculated meat were also examined. Gravy was inoculated immediately after preparation and allowed to stand on the hot-plate for three hours. Portions were removed each hour. Ultimately the gravy was incubated overnight and examined the following day. The temperatures varied from 39° to 49°C on top of the hot-plate, from 62° to 94°C inside the hot-plate and from 18° to 26°C in the kitchen.

The results were most striking from the meat slices inoculated with mixed bacilli and spores. The count of *Cl. welchii* for those standing on top of the hot-plate without gravy increased to 19.5 million in three hours, the count for those on the hot-plate with gravy increased to 2.5 million in two hours and 46 million in three hours ; there was no corresponding rise in aerobic organisms.

Inside the hot-plate, conditions were evidently lethal, because no count was obtained from these slices.

At room temperature the counts remained the same throughout, there was neither rise nor fall.

In the experiments where spores only were used the inoculum was too low and although the trend was the same, that is, germination of the spores and multiplication of the resultant bacilli on the slices kept in the gravy on top of the hot-plate, the results were not so striking. Increase in the count of *Cl. welchii* in the gravy was shown only when the inoculum was a mixture of bacilli and spores when the count increased from 500 per ml. to 100,000 per ml. in three hours. After over-night incubation at 37°C, however, the gravy counts in two experiments were 105 and 250 million per ml. of gravy.

The results of these experiments showed that *Cl. welchii* could multiply on meat slices kept at 39° to 49° C and that even in 2—3 hours the numbers of organisms could change from what might be considered a subinfective dose to one which must be assumed could give rise to symptoms.

This phenomenon is likely to be true also for other meat dishes prepared by steaming or boiling, such as minces, pies and pasties.

As it seems fairly certain that a proportion of meats are reaching canteens already contaminated with heat-resistant *Cl. welchii* then measures to protect consumers against this hazard must be taken.

Such measures may be described as follows :—

- (i) Cook the meat in such a way that all heat-resistant spores are

destroyed, i.e. by pressure cooking or by the thorough roasting of small sized joints.

- (ii) Cook, cool rapidly and maintain in the refrigerator until required.
- (iii) Cook and keep hot above 60°C either inside a hot-plate or in the steamer when the presence of gravy should make little difference.

The same recommendations should apply to gravies and stews also."

SONNE DYSENTERY is another gastro-intestinal infection which has been occurring more frequently in school children : it is reported that the National notifications during 1954 and 1955 were the highest recorded but the total number of notified cases in Essex was lower in 1955 than it had been for six years. However in 1956 the notifications increased five-fold to 1,314 and of this number 613 (almost half) occurred in children aged 5-14 years.

There was one major outbreak of the infection—at the Cranham Oglethorpe Junior Mixed and Infants' School in the South Essex Division, 195 children being absent on account of vomiting and diarrhoea. The outbreak was not confined to the school and seemed to be part of a wide-spread infection in the district ; the school, being the hub of the child population, showed up as a major focus. A smaller outbreak occurred at the Barley Lane School in Ilford involving 82 children. The respective sources of these two infections were never traced but a third outbreak at the Loughton Hall Infants School involving 41 children and also members of the staff may have originated from a food handler who was found to be a carrier.

The prevention of gastro-intestinal infection depends ultimately upon the human element. Personal hygiene, scrupulously practised, is the key to the control of most of them. For this reason money spent on the provision of any facility which makes it easier for people to observe a few simple rules of personal hygiene is money well spent. More particularly children must be taught by every conceivable method to observe these rules as part of their second nature. The most effective method is the personal example of adults.

## 11 Prevention of Infectious Disease

Towards the end of the year the Ministries of Health and Education issued a Joint Memorandum on the Closure of Schools and Exclusion from School on account of Infectious Illness. This replaced the memorandum issued in 1927 and the addendum on exclusion issued in 1942 and is advisory in character. The opportunity is being taken to revise the existing notes provided as guidance to Head Teachers in regard to the exclusion and re-admission to school of children and members of the teaching staff who have been in contact with infectious conditions. The revision will provide for some relaxation of the periods of exclusion of children who have been in contact with certain communicable diseases and will contain guidance for the school meals staff.

During the year 1956 there were the usual outbreaks of infectious diseases including mumps, chicken-pox and measles, the latter being in epidemic form.

At Harlow there was an outbreak of benign aseptic virus meningitis which started on 8th October, 1956, when the Headmistress of an infants school reported that several of her pupils had suddenly vomited at school and that some of them also had diarrhoea. In reporting this outbreak, Dr. I. Ash, Medical Officer of Health and School Medical Officer, stated :—

“ This was thought at first to be an outbreak of food poisoning, and routine investigations were started. Later in the day, however, it transpired that one of the local general practitioners had recently treated a number of patients suffering from severe headache, vomiting and neck rigidity, with diarrhoea in some cases. Other general practitioners were contacted and many of them confirmed the occurrence of similar cases. All head teachers of the local schools were then asked to report cases of sudden vomiting with headache amongst the pupils and staff and from their replies as well as from information supplied by the general practitioners it soon became apparent that there was in Harlow a major outbreak of this disease. From the 8th October up to 20th November, 84 cases were investigated, but many more persons, though known to have been affected, could not be visited and a still larger number of abortive cases have escaped notice altogether.

Twelve patients were admitted to hospital with the diagnosis of non-paralytic poliomyelitis, but although the clinical symptoms and some laboratory investigations appeared to confirm this diagnosis it nevertheless became obvious that it was not poliomyelitis but a form of benign aseptic virus meningitis. The following epidemiological factors spoke against poliomyelitis :—

- (a) very short incubation period.
- (b) absence of paralytic disease (The only paralytic case notified in Harlow occurred prior to the outbreak, and had no apparent connection with it).
- (c) high infectivity.
- (d) the frequency of multiple cases in families.

With regard to the general character of the disease the average incubation period was two to four days. Children and young adults of either sex were mainly affected, and infectivity was very high. Multiple cases in families were common and in schools infection spread very rapidly. The period of infectivity was short, however, and it was noticed that when exclusion of cases for seven days was

imposed, and especially after the half-term break from 25th October to 1st November, the number of reported cases decreased very considerably. In the majority of cases there was sudden projectile vomiting often with moderate to severe headache and occasional abdominal pain and diarrhoea. These cases recovered within 24 to 48 hours. In other cases the course of the disease was more severe. The onset was very sudden with intense headache, nausea, and/or vomiting and pyrexia. Sometimes there was a short prodromal period during which patients complained of general malaise, vague aches and pains, anorexia, and sore throat. In many cases these symptoms subsided on the second or third day, only to reappear within 24 hours with increased severity and meningism. Recovery was complete after five to eight days though lassitude sometimes persisted somewhat longer. Extensive laboratory investigation resulted only in the isolation of pathogenic virus (non-poliomyelitis) in three specimens of stools. This virus has not yet been identified but it is of interest to note that the virus research laboratory in Sheffield recovered a virus from stools of patients with very similar symptoms to those occurring in the Harlow patients and this virus was found to be related to the Coxsackie Group A."

## 12. Prevention of Foot Deformities

In January, 1956, the Committee approved an extension, for a further twelve months, of the weekly session for preventive chiropody which was being conducted in some schools in the South Essex Division. During the year the results of inspections by the Chiropodist were as follows :—

|             | <i>Totals<br/>seen</i> | <i>No. of<br/>defects<br/>found</i> | <i>Remarks</i>           |
|-------------|------------------------|-------------------------------------|--------------------------|
| 1st Quarter | 831                    | 108                                 | Mostly boys              |
| 2nd Quarter | 602                    | 108                                 |                          |
| 3rd Quarter | 365                    | 69                                  | Includes summer holidays |
| 4th Quarter | 420                    | 126                                 | All girls                |

Foot defects were found to be three times more common in girls than in boys : almost one in every three girls inspected had a defect. At least 90 per cent of these defects were found to be due to wearing ill-fitting shoes (particularly the current popular 'slip-on' casual type of shoe), which result in clawed toes, corns and pressure marks, and incipient hallux valgus. Ill-fitting shoes, and the

defects they give rise to, were found in only 35 per cent of boys, valgus ankles accounted for a quarter of all the defects.

Reference was made last year to the experimental nature of this work, and the difficulty of assessing its value. In order to obtain more precise information on this point, 100 children who were seen in September were followed up three and a half months later with the object of ascertaining whether the advice given by the Chiropodist had been taken.

Some of the children had left and some were absent when the Chiropodist visited and therefore only 80 children of the original 100 were re-inspected. The following observations were made :—

| <i>Defect</i>            | <i>Percentage of defects<br/>among 100 children seen<br/>on first visit</i> | <i>Percentage of defects<br/>among 80 of same children<br/>seen on second visit</i> |
|--------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Ill-fitting shoes        | 45                                                                          | 20                                                                                  |
| Corns and pressure marks | 28                                                                          | 12                                                                                  |
| Hallux valgus            | 16                                                                          | 16                                                                                  |
| Deformed toes            | 15                                                                          | 15                                                                                  |
| Valgus ankles            | 20                                                                          | 20                                                                                  |
| Other defects            | 2                                                                           | 2                                                                                   |

It will be noticed that there was an increased percentage of children with properly fitting shoes, with a consequent reduction in the percentage with corns and pressure marks. The percentage of more serious defects is, of course, unchanged, since these would be unaffected by treatment after so short a period.

Commenting on this follow up the Chiropodist observes :—

“ My general impression on this second visit was that nearly all the children remembered what I had told them previously about their feet and shoes, and a great many of them had made a real effort to improve their footwear, so that the percentage wearing ill-fitting shoes decreased considerably. A few had made the effort to get larger shoes, but had still failed to get them long enough for the great toes, which is of course most important, particularly in the case of abnormal great toes owing to the pre-disposition to hallux valgus. Quite a number of the girls still insisted on wearing ‘slip-ons,’ but at least they had tried to get them long enough. One of the most difficult things is to try and convince a child that her shoes are too small, when she says they feel too big and are loose round the heel and instep owing to the lack of support in the shoe.”

The Head Teachers of the schools have confirmed, from more general observation, the value of this experiment. The gymnastics mistress in the school

in which the follow up was made, who is a qualified remedial gymnast, provides special exercises to correct some of the minor foot deformities found.

It is considered that the results justify the experiment so far, and in order to enlist the co-operation of parents, and to permit of further inspections in more schools, particularly in the urban areas, approval has been given by the Committee for one additional weekly session to commence in 1957.

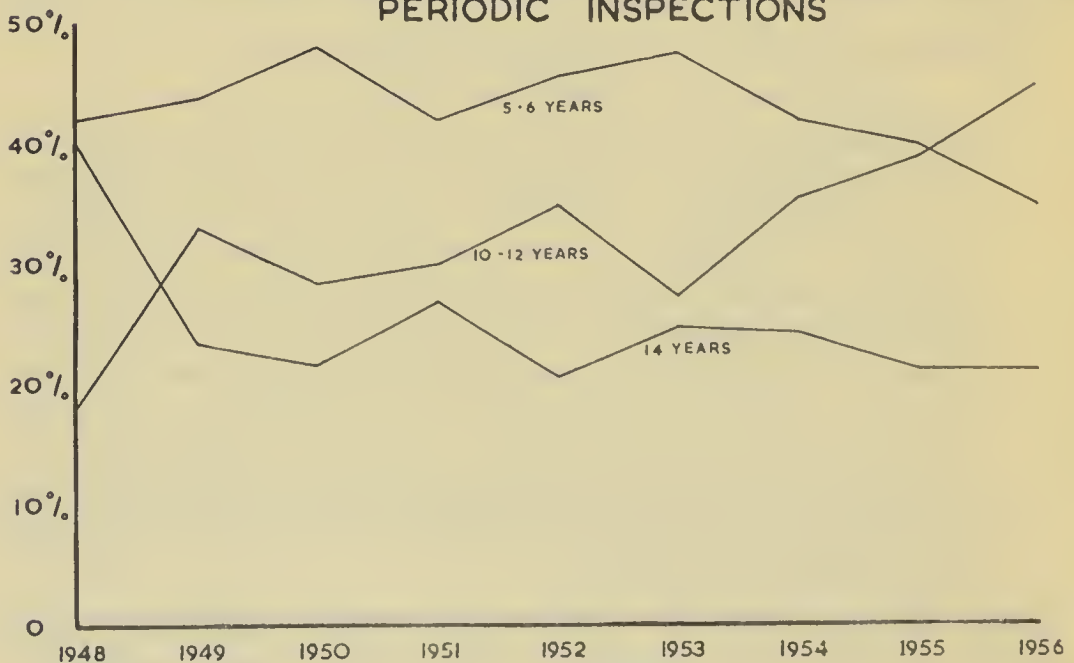
### C. ASCERTAINMENT AND TREATMENT

The proportion of children found at periodic medical inspections to require treatment remained steady during the year at 15.5% compared with 15.3% the previous year.

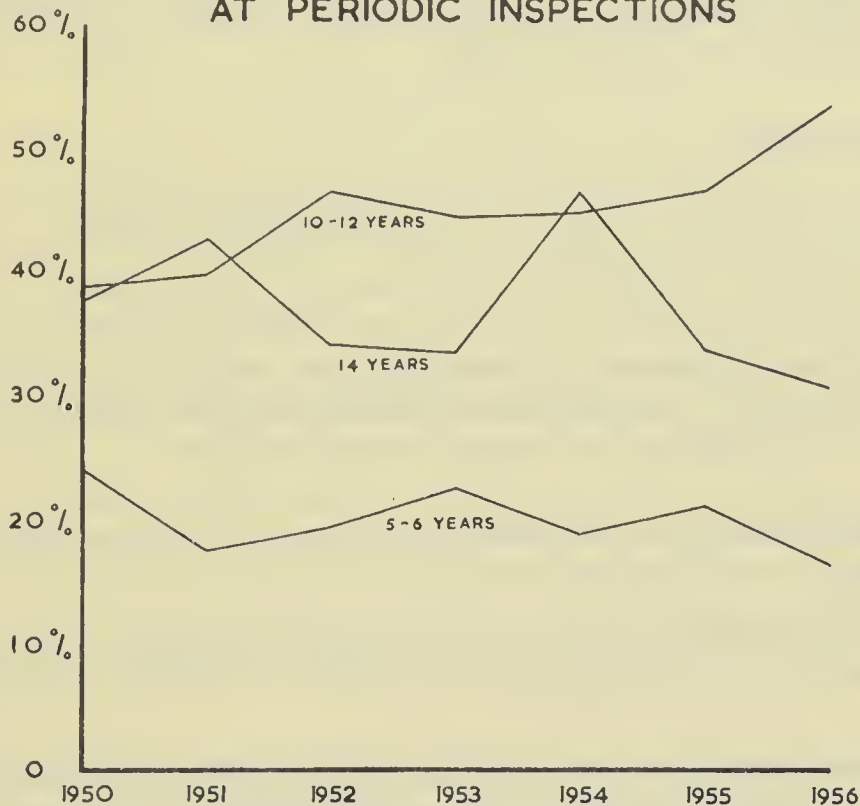
The incidence of the three main conditions requiring treatment continued ; defective vision and squint increased to 5.3% and diseases of the nose and throat fell to 1.7% per 100 children inspected. The incidence of orthopaedic defects requiring treatment was the same as last year.

The tendency for an increasing proportion of children in the 10-12 years group to be found to require treatment for some defect has also continued in spite of the fact that there are almost twice as many children of primary school age. It would appear that the tendency is at least partly due to the increasing proportion of children in this age range who require treatment for some visual defect (excluding squint). These trends are shown in the two graphs below.

PROPORTION OF CHILDREN, IN AGE GROUPS,  
FOUND TO REQUIRE TREATMENT AT  
PERIODIC INSPECTIONS



**PROPORTION OF CHILDREN, IN AGE  
GROUPS, FOUND TO REQUIRE TREATMENT  
FOR DEFECTIVE VISION (EXCLUDING SQUINT)  
AT PERIODIC INSPECTIONS**



One of the facts revealed now that particulars of defects found at periodic medical inspections are notified in age groups is that one third of the children found to have a squint requiring treatment were of school leaving age. This is a matter which needs further investigation.

### 13. Diseases of the Nose and Throat

Because of the clear need for more accurate information relating to tonsillectomy in school children in the light of the wide variation in the number of children who have had the operation not only in different parts of the country but also in the Divisions of large counties, the Minister of Education asked that during 1956 School Medical Officers should note on the school medical record cards at periodic medical inspections which children had undergone tonsillectomy. With these figures and those in subsequent years it will be possible to start an intensive study of this problem.

The statistics for Essex are detailed in Table 2 (Appendix B page 72). From this it will be seen that 6.6% of children had their tonsils removed by the time they entered school, whilst 17.4% of 10-12 years old children and 16.4% of school leavers had also had the operation, the rates being approximately equal for boys and girls.

When these figures are broken down on a Divisional basis (Table 3) the low rate of tonsillectomy in Mid-Essex again stands out : 0.6 % of school entrants as compared with the range for school entrants in other Divisions of 5.1 %—12.1 % and for the older children a rate of 1.2 % compares with an average rate of 16.6 % elsewhere although the rates in South East Essex and Dagenham were also noticeably lower than this average.

#### **14. Otitis Media**

It is encouraging to report that both the incidence and number of cases of otitis media requiring treatment continue to decline ; in 1956, 216 children required treatment, operations being necessary in 20 % of these. For every child requiring treatment, however, there are probably another two who need to be kept under observation. Diseases of the nose and throat and otitis media are third on the list of conditions requiring treatment during school life, and the main disability following aural disease is a hearing defect.

#### **15. Arrangements for the assessment and treatment of children with defective hearing**

The resignation of the audiometrician in May 1956, led to a review of the arrangements for the assessment and treatment of children with defective hearing.

As mentioned in a previous report the fundamental aim of the arrangements is to enable a child with defective hearing with the help of either a hearing aid or lip reading or both to understand speech, and to talk.

Before he can speak a child must be able to understand speech and there is a critical period between approximately 18 months and 3 years during which the hearing child normally has a special facility for listening and interpreting sounds. When listening and speaking are delayed beyond this period of election the understanding of speech and speaking become increasingly difficult to learn.

There are two main groups of children with defective hearing ; those born deaf or who become deaf before they have learned to speak and those who become deaf after speech has been established. Children in the first group if they are diagnosed early, trained by auditory and visual methods, and helped by hearing aids where this is possible, can now either acquire sufficient speech and understanding of the spoken word to be educated in a normal school, or (where the hearing loss is very severe) attain a level of communication through speech and hearing far higher than used to be the case. The social and educational implications of this are great but the extent to which an otherwise normal child can appreciate them depends entirely on the level of communication to which he has been trained in his pre-school years. As regards children in the second group, most of the conditions causing their deafness are amenable to treatment (which is, most properly, provided by the general practitioner and hospital services) but they do present an educational problem whilst the hearing loss

exists. There remains, however, a minority of cases where the deafness is severe and permanent and, in order to conserve their instruction in speech, lip reading is required from a teacher of the deaf in addition to the provision of hearing aids.

Among the essentials for an efficient scheme for the ascertainment and treatment of children with defective hearing there is need to provide for :—

- (a) The earliest possible discovery of deafness.
- (b) The ascertainment of the degree of residual hearing, and
- (c) Facilities for special treatment, including auditory training, lip reading and education.

#### (a) DISCOVERY OF DEAFNESS

The discovery of deafness during the first few months of a child's life must always be a matter of major importance and reliance in this respect is placed on the observations of parents, family doctors and the medical, nursing and auxiliary staff at child welfare clinics. Unfortunately this is not always sufficient.

During her seven years' service in the County, the Audiometrician carried out one survey in each of the four Divisions of Barking, Ilford, Dagenham and Forest and two surveys in each of the Leyton and Walthamstow Divisions but at no time was it possible for her to survey school children in any of the rural Divisions.

Furthermore because the gramophone audiometer requires, for group use, a certain familiarity with the recognition and writing of numbers which children of 4—7 years do not always possess, such surveys as were carried out dealt only with children over the age of 8 years.

From the eight surveys which were made the following facts emerged :—

- (i) The percentage of children aged 8-14 years who failed the gramophone test and who were referred for treatment, varied from 1.3 % to 3.1 % and averaged 2 %.
- (ii) The percentages of such children in the two surveys in Walthamstow were 1.9 % and 3.1 % and in Leyton 2.1 % and 1.5 % ; the average percentage in these second surveys was 2.3 compared with 1.9 for the first surveys.
- (iii) About one-third of the children found to have some degree of deafness were receiving or had received treatment for the condition causing their deafness but two-thirds of those undergoing treatment were not previously known to be deaf.
- (iv) More than one third of the children had normal or improved hearing following treatment.
- (v) In the two surveys (Walthamstow and Leyton—1949/50) 1.9 % and 1.8 % respectively of children in ordinary schools were referred for treatment for deafness, whilst 11.6 % and 5.5 % of children in special schools were likewise referred.

These facts taken in conjunction with the known variability of the deafness of children with catarrhal conditions of the ear, nose and throat, indicate the need to extend the facilities for audiometry to children on entry to school, and to those in the rural Divisions.

As one of the first steps in the implementation of a comprehensive service for deaf children, the pure tone audiometer which the Committee already possesses has been issued to the North East Essex Division. Initially School Medical Officers undertake routine audiometer testing of school entrants and specially selected groups of children in whom deafness is likely to be relatively common, i.e. those in special schools (particularly Educationally Sub-Normal children), those attending speech therapy classes and those with recurrent upper respiratory tract and aural conditions.

A second pure tone audiometer has been issued to the Barking Division for similar use. From these two pilot surveys in contrasting rural and urban Divisions it is hoped to obtain information and experience which is needed before extending similar facilities to all the other Divisions.

#### (b) THE ASCERTAINMENT OF RESIDUAL HEARING

The ascertainment of residual hearing in individual children is at present carried out by otologists at the out-patient departments of the following hospitals :—

Essex County, Colchester  
Chelmsford and Essex, Chelmsford  
Southend-on-Sea General  
Oldchurch, Romford  
St. Margaret's, Epping  
Whipps Cross, Leyton  
Connaught, Walthamstow

In addition, children attend the Westminster Hospital, the Metropolitan Ear, Nose and Throat Hospital, the Grays Inn Road Audiology Unit, London and the West Ham Audiology Centre.

#### (c) FURTHER DEVELOPMENTS

As neither the Regional Hospital Boards nor the Committee provide a centre in the County where auditory training and lip reading as well as advice to parents on the handling of deaf children and other special educational needs can be given, children from Essex requiring such training have to go to London. The Grays Inn Road Audiology Unit in particular has a long waiting list for first appointments and it cannot always provide the frequent training that is necessary.

Miss M. M. Mason, F.R.C.S., the Consultant visiting the Barking and Ilford Ear, Nose and Throat Clinics, refers to this in her report upon the work of the Ilford Clinic :—

“ An increasing number of children are referred for examination

with regard to their hearing, and I am pleased to observe that in many instances this matter is first raised by the parents, who are becoming more 'deafness conscious.' I would still wish to see the establishment of a specialised deafness clinic for the over-fives in this area. Although we receive the most helpful co-operation from the Audiology Unit in Grays Inn Road, they serve such a large area that, despite the most noble efforts on the part of the staff, patients often have to wait several months before an appointment can be given ; and if a period of auditory training is advised, the necessary journeys are costly in both time and money."

A proposal to set up Audiology Clinics, staffed in the first place by an otologist and teacher of the deaf, to meet the need is now under consideration; the work will require to be closely integrated with the provision of special educational treatment for children with defective hearing.

## 16. Speech Therapy

The approved establishment of Speech Therapists is 21 ; at the end of the year the equivalent of 20 full-time posts were filled. Many of the therapists are employed on a sessional or part-time basis and moves are fairly frequent but it is hoped that early next year the establishment will be complete.

Reference was made in last year's report to the experiment of group speech therapy. Mrs. S. Powell, the Speech Therapist in charge of these groups in the Forest Division reports :—

" Group treatment for children between the ages of  $3\frac{1}{2}$  and 5 years at Woodford and Hatch Lane Clinics was commenced in May, 1956.

There are now three groups, two at Woodford and the other at Hatch Lane. In each group four to six children all of whom have been referred for retarded speech, but appear to be of average intelligence attend for one hour each week. The child is treated in a group for exercises of his speech mechanisms, but is taken individually for about ten minutes for work on a specific sound, repetitive and association picture matching etc. He then plays for the remainder of the period with freedom to choose what he wants to do.

The clinics are well equipped with a variety of books, puzzles and constructional toys, but the most popular apparatus is the sand and water tray. Girls love to bath the baby doll, and dress and undress it.

I am convinced that this method of treating children with retarded speech is far preferable to the child being treated solely by himself. At home he is different from the others in the family circle, frequently he is frustrated and highly nervous, and the parents' over-anxiety about his speech only increases his nervousness and reluctance to speak.

Being with other children similarly handicapped, encourages him to try and express himself, he develops a social awareness, and gains a feeling of security in the quiet happy atmosphere of the clinic. The important factor in my opinion is that the child comes to the clinic to

play with other children, and does not feel speech conscious, the emphasis is on play not speech.

Parents feel it is a good preparation for school, and are most co-operative. Their anxiety is considerably lessened, and they are appreciative of what is being done to help their child. Two children who were making little progress before they came into the group improved tremendously in a very short time, when they were no longer treated by themselves."

Mrs. M. Walker, one of the Speech Therapists in the Ilford Division mentions another experiment :—

" This is the first year that a clinic has been held in an Ilford School, and although it is still an experiment, it is interesting to note the advantages and disadvantages of working on school premises.

Attendance is more regular, resulting frequently in a quicker discharge rate, and there is of course greater opportunity for discussion with teachers. Apprehensive children can attend with their friends, and by not removing the child from his daily surroundings not only is less attention drawn to the speech defect, but far less schooling is lost than when travelling to and from an outside clinic. On the other hand, there is the disadvantage of seeing parents far less regularly."

There has been a great demand for the four tape recording machines available for use in speech therapy clinics throughout the County. They are a valuable adjunct to treatment in selected cases of speech defect and speech therapists who have used them report that they also assist greatly in making correct diagnoses. The machines have also proved to be valuable in helping children to appreciate their own particular defect and in stimulating them to fuller effort whilst under treatment. It is now clear that the occasional use of a machine on loan for a limited period is neither adequate nor satisfactory for the purpose of conducting speech therapy for individual children. Additional machines were purchased towards the end of the year and it is hoped that there will be now one machine available for each Division.

## **17. Orthopædic Conditions and Physiotherapy**

Nearly four out of every hundred children examined at periodic medical inspections were found to require treatment for some orthopædic defect. The treatment is at present carried out as part of the specialist services provided by the Regional Hospital Board but because of the very large number of children requiring treatment it has not always been possible to provide it as frequently as would be desirable ; in some parts of the County owing to the difficulty of obtaining physiotherapists the treatment has not always been readily obtainable.

Physiotherapists have been appointed to clinics by arrangement with the appropriate Hospital Management Committees and the normal procedure is for a child who is thought to need treatment for some defect to be referred to an orthopædic specialist, either at a hospital out-patient department or at a school

clinic. Much of the treatment prescribed by the consultants is carried out by the physiotherapists. Liaison between school medical officers, orthopædic specialists and physiotherapists in some areas has improved considerably following discussions between the three parties and as a result a number of minor orthopædic defects, in the first instance, are treated by physiotherapists at the request of the school medical officer ; there has been a consequent saving of time and a reduction in the long waiting lists for consultant opinion.

One remaining difficulty, however, is the shortage of physiotherapists. This has been referred to in a number of reports from the Divisions ; for instance, Dr. W. J. Moffat (South East Essex), writes :—

“ Owing to difficulty experienced by the respective Hospital Management Committees covering this division in obtaining the necessary staff, it was possible to provide only a limited service under this heading during the year. It was hoped that the physiotherapy sessions held at the Craylands Health Services Clinic, Basildon, under the auspices of the Tilbury and South East Essex Hospital Management Committee would recommence at the beginning of 1956, but this was not found possible. Eventually, however, a physiotherapist was appointed by that Hospital Management Committee, and from June, 1956, a weekly session was held at this clinic on Thursday afternoons.

It was not possible for a similar service to be undertaken for school children in the eastern part of the division, as the Southend Hospital Management Committee were not able to make an appointment of a physiotherapist. Consequently, children suffering from minor orthopædic defects have to attend at the Southend Hospital for examination and treatment. This arrangement involves additional travelling and expense to the parents in attending with their children, with the result that many do not attend.”

Dr. W. T. G. Boul (South Essex), reports :—

“ Physiotherapy sessions for school children re-commenced on the Aveley Estate at the Health Centre in March and sessions were also re-started at the Grays North Health Services Clinic. Unfortunately, these have again lapsed through the resignation of the Physiotherapist who is emigrating.

Physiotherapy in the Thurrock area has, for the last few years, presented a problem through the inability of the local Hospital Management Committee to recruit staff.”

The position in Leyton is particularly difficult ; the orthopædic clinic having been without the services of a physiotherapist for more than six years, in consequence of which children requiring special exercises have had to attend the Whipps Cross Hospital. About a year ago, the hospital informed the Divisional School Medical Officer that they were also having difficulty in obtaining staff to do this remedial exercise work but fortunately, at the same time the Committee's physical education organiser for the area suggested that the services of

two physical education teachers who had special training in remedial exercises might be used. After consultation with the orthopædic consultant, half-hourly remedial exercise classes were started on two evenings a week at the Health Area Office as an experiment. During the last twelve months courses of six to eight weeks' duration have been held. Fifty-two children have attended, six of them over the whole period. The average attendance at each session has been six. A few of the children have been referred direct by school medical officers but most of them have been referred from the orthopædic clinic and the consultant himself has supervised their progress. The results have been sufficiently satisfactory to consider extending the service to include other exercises in addition to foot exercises.

A large measure of the remedial work at present being undertaken by physiotherapists could be done equally well by remedial gymnasts—the returns for the last few years show that between 40 % and 50 % of the orthopædic conditions requiring treatment are defects in posture or the feet. It is also worthy of note that, during the last full year that a physiotherapist was employed at Leyton, of 237 children receiving treatment, corrective exercises were being given for foot conditions in 73 cases, for posture in 47 cases, and for chest conditions in 29 cases. These are the exercises which a remedial gymnast is particularly qualified to give. There is here a field for co-operation between two branches of the educational service and it is hoped to report more fully next year on this work and in regard to the possibility of extending the scheme at present being operated in Leyton.

## 18. Psychological conditions and the Child Guidance Service

More children were found at routine medical inspections during 1956 to require psychological treatment than in previous years although the incidence of conditions requiring such treatment remained steady at 0.4 per cent of children inspected. One third of these children were of school entry age ; altogether 637 children were referred for treatment from periodic and special medical inspections.

The Child Guidance Clinics have endeavoured to meet the increased demand made upon them ; more children were diagnosed and the waiting list for diagnosis was reduced by 20 per cent. Several of the psychiatrists have referred to this in their reports.

Dr. H. N. Davy (North East Essex Clinic) said :—

“ A point of criticism of Child Guidance procedure all over the country has been the time-lag between the date of referral to the Clinic and the date of the diagnostic interview, and the period of waiting before children can be taken on for regular treatment. This autumn I worked under pressure and cut the first time-lag to close on one month by bringing up—in a bunch, as it were—a number of families together in order to make a brief assessment as to which problems would respond to simpler measures and which families called for more intensive and detailed treatment.”

Dr. J. E. G. Vincenzi (Mid-Essex Clinic) stated :—

“ A determined attempt was made to cut the waiting list as previously it has been two years or more before children who had been referred could be seen at the Clinic, and 196 diagnostic interviews were given as opposed to 160 in 1955 and 185 in 1954. The waiting list for diagnosis is 97 ; this represents about 10 weeks wait. This could be lowered but for the fact that Court cases have to be given an absolute priority, and these average one a week.”

Dr. Murray Jackson (South Essex Clinic), reported :—

“ When I started in April, 1956, the clinic was already in existence. Most necessary contacts had been made, and a great deal of work had been done with the result that, when I began, there was a waiting list for diagnosis of over 150. By concentrating on diagnostic evaluation, it has been possible to bring this list down to about 70 and I hope that with more child therapist sessions, we will now be able to do more intensive treatment of children and families.”

The problem of overcrowding at Child Guidance Clinics is, however, more complex than at first appears because the character of the work of the clinics is gradually changing ; minor problems of adjustment and social and educational weakness are being increasingly dealt with by School Medical Officers and school nurses with the result that the clinics have a much higher proportion of the more difficult patients to help.

Dr. H. N. Davy discusses this :—

“ The more effective the screening process is, the more difficult will be the problems that eventually arrive at the clinic. These problems involve a great deal of extra effort and time. The diagnostic interviews alone are very time consuming and take 3 to 4 hours of the team's time. Difficult individual, medical, family and sociological problems are presented. Many maladjusted children have to be found residential placement in schools, hostels and hospitals. Some are adopted children, some come from broken homes, some are handicapped children.

A great deal of time and effort has to be spent in matching the needs of each individual child—emotional, medical and academic to a suitable residential school or hospital unit. Places for the older children are very hard to find. Considerable psychiatric time has to be given to the parent and to convince the child that such a residential placement is not a rejection by the parent. It may seem strange at first sight, but it is the maladjusted child who, having tormented his home and school, then has the greatest difficulty in adjusting to a new environment and to a new school. It takes one or two terms and the holidays for this settling-in of the maladjusted child. Residential placement is not the end of the Clinic team's work on this child. The progress of these disturbed children in their respective schools and home relationships has to be constantly reported on. Both parents and their children are seen or visited during the school holidays. Some parents of children helped and placed ten years ago still come to the clinic for advice.”

It is inevitable that as a result of this more difficult type of work, and the concentration on diagnosis, the amount of intensive treatment should be somewhat reduced. Although a greater number of children have been treated or were under treatment during the year than in 1955, fewer have been discharged with treatment completed and more of those who have been diagnosed are awaiting treatment. (See table 4 Appendix B, page 74).

One of the great problems facing the Child Guidance Service is the lack of in-patient units for young children and adolescents requiring observation or treatment. The nearest unit for children under the age of six years, is outside the area served by the North East Metropolitan Regional Hospital Board. At most other hospitals where treatment can be obtained, there is accommodation only for children under the age of twelve years or over sixteen years. The adolescent unit at St. Ebba's Hospital, Epsom, and the Maudsley Hospital, London, have long waiting lists and are not equipped to deal with long-term cases. Yet children who are deeply disturbed are really not properly placed in schools for maladjusted children ; what is required is that the Regional Hospital Board should provide a small hospital school of perhaps eight to ten beds where these children can have prolonged observation, treatment and education. The serious lack of suitable accommodation of this nature is again referred to by Dr. H. N. Davy in his report on the Homestead School.

In his report on the work of the North East Essex Clinic, Dr. Davy remarks:

"More and more I have come to believe that our primary aim should be not to merely treat the maladjusted child, but preventive work to help the community as a whole, and the young parents in particular, how to adjust themselves and to bring up well-adjusted children.

If pressed, I would say our commonest treatment problems and successes are those when parents are helped to accept children's independence (their's and the child's) and growing-up pains. We do see many immature, retarded and frightened or rebellious children grow emotionally in character development and intellectual attainment. But it is not the kind of growth that can be neatly tabulated in statistics. (Some cynics would say that this would have happened whether they had attended the Child Guidance Clinic, or not). A recent report in "The Times" indicated that in those parts of England served by Child Guidance Clinics, there is a far lower incidence of delinquency than in those districts which have no Child Guidance Clinics."

Increasing attention is being paid to the preventive aspect which is an integral part of the clinic's work. Dr. Susannah Davidson (Ilford Clinic) described the efforts made in this direction at Ilford :—

"We have had one meeting with the Ilford Health Visitors to discuss how best we can co-operate in the preventive work and it was decided that they would contact us again when they had collected several cases which merited joint consultation. Meanwhile, a number of Health Visitors have visited the Clinic and taken part in case conferences where they have had an opportunity to see how we worked and the type of case we treated.

We have had many visitors to the Clinic, and though they cannot be present during the therapeutic interviews, we welcome them to the Case Conferences. We have had School Medical Officers, General Practitioners, Social Workers, Health Visitors, Probation Officers and Children's Officers. We have had two Psychology Students working with us for periods of a month, and Health Visitor Students, and a Student from the Training Course for Teachers of Maladjusted Children who have been to us for visits of observation.

We have had an Exhibition of Books for children of limited reading ability which has been seen by all the Head Teachers and most of the Assistant Teachers of the area, and a course of lectures has been given to Head Teachers on Grammar School allocation. Lectures have also been given to Parent-Teachers' Associations. We have continued to send representatives to the Co-ordinating Committee of Social Workers in Barking."

Dr. J. E. G. Vincenzi (Mid-Essex Clinic) reported a steady increase in the number of children referred to the Clinic by general medical practitioners—43 in 1956, 27 in 1955 and 8 in 1954.

Dr. Helen Gillespie (West Essex Clinic) reported that a number have had to be referred to that Clinic from Child Psychiatric Clinics in London because they are also overcrowded with cases awaiting treatment. This reference from one clinic to another tends to militate against successful treatment.

In her report on the School Psychological Service, Miss E. M. Bartlett refers to the important part that this Service plays in dealing with many minor forms of maladjustment which develop early and which first reveal themselves at school :—

"The Staff of nine psychologists has remained unchanged throughout the year, and the number of children interviewed at the request of Heads of Schools has also remained steady at 2,640, i.e. about one per cent of the school population. Of these, some 190 children were found to be so maladjusted that they needed to be sent on to the Child Guidance Clinics. This underlines the value of a School Psychological Service, is very closely intergrated with it, since the majority of these children were referred in the first instance for educational difficulties, and so might not have received the psychiatric help they needed if they had not been seen by a psychologist. In this connection, it is interesting that the proportion of children of average or above average intelligence who are referred to the psychologists is steadily rising, and at the moment is between 60 and 70 per cent of the total number. This is as it should be. Teachers should be able to distinguish those children whose main handicap is straightforward lack of intelligence, referring these to the School Medical Officer, from those whose school failure stems from a complex of factors, sending only this type to the psychologists. This growing perceptiveness among teachers is also reflected in the steady increase of part-time remedial teaching groups for children of reasonably good intelligence, organised in the schools in co-operation with the psychologists.

The function of the school psychologist is not to do a teacher's work for him, but to help him to meet the needs of children presenting difficulties of a specialised kind. Many schools have classes for backward children of poor ability, and often do not consult the psychologist about the selection of children for them, but it is becoming increasingly apparent that educational backwardness is often the result of a very complex pattern of factors and that a variety of measures is needed to cope with it. Only some of these require the help of a psychologist. Shortage of teachers makes any expansion of this work difficult at the present time, but remedial groups for maladjusted children have been established at the Grays and Colchester Clinics.

In other respects, the work of the psychologists has been on the usual lines. On an average, each psychologist has paid about 40 visits to schools on behalf of children attending Child Guidance Clinics, discussing their progress with the teachers and advising on their handling at school while undergoing treatment. The psychologists have also seen a great many of the parents of children referred through the School Psychological Service. Interviews of this kind are a great help in deciding on the seriousness of a child's difficulties, and in treating many of them within the school situation.

Lectures to teachers, discussion groups with the teachers in charge of remedial classes, and talks to Parents' Associations and other Groups have continued as usual, and help has again been given with a Home Office Residential Course for House-parents. One of the Teachers studying for the Diploma in the Education of Maladjusted Children at London University, is attending the Mid-Essex Child Guidance Clinic for part of his practical work."

### 19. Other Special Clinics

Dr. J. M. Pooley (School Medical Officer) reports as regards the enuresis clinic at Ilford that 41 sessions were held during 1956 and that 376 children attended. Seventy-one of these were new cases, referred from the following sources :—

| <i>Recommended by</i>                    | <i>Under 5 years</i> |       | <i>Over 5 years</i> |       |
|------------------------------------------|----------------------|-------|---------------------|-------|
|                                          | Boys                 | Girls | Boys                | Girls |
| Parents       ....       ....       .... | 1                    | —     | 2                   | —     |
| General Practitioners       ....         | 1                    | —     | 1                   | —     |
| Infant Welfare Centre Officers           | 7                    | 2     | —                   | —     |
| School Medical Officers       ....       | 3                    | 2     | 32                  | 19    |
| Health Visitors       ....       ....    | 1                    | —     | —                   | —     |
|                                          | 13                   | 4     | 35                  | 19    |

He states that treatment procedure adopted in previous years has been followed at each session. A most important aspect of the treatment is the approach to

the child and parent and much time is spent in discussing the problem with each. So far as 11 children were concerned, advice and charting were all that was necessary ; in the case of the remaining patients this was supplemented by medical treatment, usually emphetamine sulphate (2.5 m.g.m. to 10 m.g.m. per night) but 4 children were given phenobarbitone and three boys pituitary snuff. In addition four of these children were referred to a hospital or a Child Guidance Clinic. Results have continued to be encouraging ; 46.6 % have been completely cured after an average of four attendances and 70 % have shown marked or very marked improvement. In the younger and more impressionable children (i.e. those between five and eight years of age) better results occurred when they were seen at intervals of four weeks rather less frequently ; this maintained their interest.

In some cases treatment has been prolonged and extended into the second year but the end result has been a complete cure. Of the 67 new cases treated during 1955 a total of 49 (73 %) were eventually discharged completely cured, 24 of them during 1956.

#### **D. SPECIAL EDUCATIONAL TREATMENT**

##### **HANDICAPPED PUPILS**

##### **20. Blind and Partially-sighted Children**

There has again been little deviation from the figures of previous years relating to children ascertained as blind or partially-sighted. (See table 5 Appendix B, page 75). Except where there is an additional handicap, there is little delay in placing these children in suitable schools and the waiting list has not increased significantly. For many years past rather more partially-sighted children have been accommodated in residential schools than in day schools, (although the Committee has its own day school, the Joseph Clarke School in Walthamstow) mainly because of the transport difficulties in connection with transport experienced by children in rural Divisions.

The Joseph Clarke School has accommodation for 45 children, aged from 5 to 15 years, and serves a mainly urban area with a radius of 15 miles from Walthamstow including part of the neighbouring County of Middlesex. The criterion for admission is that a child should have a visual acuity of 3/60ths to 6/24ths with glasses or the prospect of deterioration to this extent. There are three classes, each with a maximum of 15 children who are divided into approximate age groups, each consisting of children with varying abilities. All the staff are qualified to teach the partially-sighted. School hours are from 9.30 a.m. until 3.15 p.m. and the most striking impression which is obtained on visiting the school is its similarity to an ordinary school. The time table includes most of the usual subjects including some science in the group of oldest children.

The trend used to be to conserve sight, but now everything is done to make the best possible use of what sight the children have. They are encouraged

to use their vision, even if it requires very close focussing and it is rare to see them using books printed with a type which is much larger than normal. Ordinary school furniture is provided ; each class-room is wired for radio reception and little special equipment is used. Full use is made of games and other physical activities except, for special reasons, in individual cases.

The outstanding differences between this and other school buildings are the lighting provided in the class-rooms, the period of rests, and the quieter tempo. A good even standard of illumination is the best aid to seeing for the partially-sighted ; rooms need to have good natural and artificial light, with no glare and suitable decoration for walls and ceilings. The natural lighting in the class-rooms is augmented by tube lighting and the illumination is tested by a photometer at the beginning of each term because tubes decrease in efficiency with use.

Most of the children have rest periods ; in the youngest group for 30 minutes at a time, in the middle group 20 minutes, and in the eldest group 15 minutes. The size of the groups allows of much individual teaching.

A Consultant Ophthalmologist, nominated by the North East Metropolitan Regional Hospital Board, visits once a term to examine and give specialist medical advice. Each child has a spare pair of spectacles and with the co-operation of a local optician spectacles are repaired with very little delay.

Such other diagnostic, preventive and curative remedial services as are required are provided in the usual way through the School Health Service.

It is interesting to note the visual acuity and the condition which required the admission of the 44 children in the school at the end of the year.

*Visual acuity :—*

|                       |      |      |      |          |
|-----------------------|------|------|------|----------|
| Less than 6/60ths     | .... | .... | .... | 7        |
| 6/60ths               | .... | .... | .... | 13       |
| 6/36ths               | .... | .... | .... | 11       |
| 6/24ths               | .... | .... | .... | 5        |
| 6/18ths               | .... | .... | .... | 8        |
|                       |      |      |      | <hr/> 44 |
| Monocular vision only | .... | .... |      | 12       |

*Conditions for which referred :—*

Congenital cataract  
 Errors of refraction  
     high myopia  
     myopic astigmatism  
     anisometropia  
 Albinism  
 Optic atrophy  
 Microphthalmus  
 Coloboma  
 Detachment of the retina  
 Choroditis  
 Retinitis albicans  
 Abiotrophy

Compared with the practice prior to 1950, myopic (short-sighted) children are being admitted much less frequently, probably as a result of recent advances in knowledge regarding this condition, and of experience of the effect of increased activity, both visual and physical, on partially-sighted children. For instance, of 27 children, admitted prior to 1950 of whose visual acuity there is record, 21 were high myopes, and after correction they had the following vision :—

|                   |      |      |      |    |
|-------------------|------|------|------|----|
| 6/12ths or better | .... | .... | .... | 13 |
| 6/18ths           | .... | .... | .... | 4  |
| 6/24ths           | .... | .... | .... | 2  |
| 6/36ths           | .... | .... | .... | 1  |
| 6/60ths           | .... | .... | .... | 1  |
|                   |      |      |      | —  |
|                   |      |      |      | 21 |
|                   |      |      |      | —  |

During the period of Mr. G. M. William's Headmastership (from 1950 up to the present time) 83 children have passed through his hands ; 22 have left upon taking up employment, varied according to visual acuity, intelligence and personal character as follows :—

|              |      |      |      |    |
|--------------|------|------|------|----|
| Factories    | .... | .... | .... | 8  |
| Offices      | .... | .... | .... | 6  |
| Shops        | .... | .... | .... | 3  |
| Horticulture | .... | .... | .... | 2  |
| Hospitals    | .... | .... | .... | 3  |
|              |      |      |      | —  |
|              |      |      |      | 22 |
|              |      |      |      | —  |

Two of them were registered under the Blind Persons Act 1938 and ten under the Disabled Persons (Employment) Act 1944.

The useful work done at this school in assessing the special educational needs of the children admitted is shown by a study of a follow-up of the other 61 children admitted during the last seven years as follows :—

|                                |      |      |      |    |
|--------------------------------|------|------|------|----|
| To residential schools for the |      |      |      |    |
| partially-sighted              | .... | .... | .... | 11 |
| To grammar and high schools    | .... |      |      | 4  |
| To ordinary schools            | .... | .... | .... | 18 |
| To technical school            | .... | .... | .... | 1  |
| To schools for the blind       | .... | .... | .... | 15 |
| Died                           | .... | .... | .... | 1  |
| Left the district              | .... | .... | .... | 8  |
| Declared ineducable            | .... | .... | .... | 3  |
|                                |      |      |      | —  |
|                                |      |      |      | 61 |
|                                |      |      |      | —  |

Constant revision of a child's progress has to be made, by joint discussion between the ophthalmologist and teachers for the purpose of achieving whenever possible the child's return to an ordinary school. The visual acuities of the 18 pupils mentioned above as so transferred, varied at the time of transfer from 6/18ths to 6/24ths. Three of them had cataract, three had myopic astigmatism, two congenital nystagmus, one albinism and nine myopia. In the latter, vision had been stabilised for at least twelve months.

The work of this special school has been especially valuable to the children in the age range 5-12 years, with visual acuities 6/60ths to 6/24ths. The factor of intelligence is, of course, important ; a child of good intelligence and a visual acuity of 6/24ths may be able to manage in a normal school, whereas many of lesser intelligence and a visual acuity of 6/18ths fall behind their contemporaries in such a school, and undoubtedly benefit, in the early years at any rate, from attending a special school for partially sighted children.

## 21. Deaf and Partially Deaf Children

The number of children found in 1956 to be partially deaf and needing special educational treatment was 16, the highest recorded during any year since 1950.

Over the same period, however, there has been a steady reduction in the number of deaf children found annually to require special educational treatment. This is a welcome trend which seems to indicate that children with defects of hearing are being discovered at an age early enough to enable them to be taught to speak sufficiently well to be eligible for a school in which the major emphasis is on auditory rather than visual methods of communication.

It is perhaps too soon to expect any reduction in the number of children in schools for the deaf or an increase of partially-deaf children in ordinary schools although this is to be anticipated as a result of advances in the auditory training of young deaf children. The number of children in residential schools for the deaf in 1956 remained steady during the year and there was only a slight drop in the number of children in schools for the partially deaf. (Table 6(a), Appendix B, page 76).

The waiting period for admission to residential schools for the partially-deaf is now approximately two years ; this results from the reorganisation instigated by the Ministry of Education, whereby deaf and partially-deaf children are not now educated in the same school. The East Anglian School for the Deaf at Gorleston-on-Sea which previously admitted many deaf and partially-deaf children from Essex is in consequence now taking only deaf children.

The resulting period of change offers an excellent opportunity for reviewing the placement of all children with defective hearing, bearing in mind the need to avoid segregating those with severe partial deafness in schools for the deaf and those who are less severely partially deaf in schools where they have no contact with children with normal hearing. The tendency is for an increasing

number of partially deaf children to be educated in ordinary schools with or without hearing aids and if necessary either in special part-time classes or with extra tuition from a part-time teacher of the deaf. In Leyton, for instance, two such children are attending a normal school and receiving this extra tuition. This appears to be the correct outlook provided discretion is used in assessing a child's ability to benefit from normal education, progress is carefully supervised, teachers are made aware of special needs and, especially where a child is young or has recently become deaf, adequate facilities exist for the necessary auditory training and teaching in lip reading. Only teachers of the deaf are really qualified to satisfy these latter provisions.

A survey was made during 1956 of the placement of each child known to be so defective in hearing that he required some form of special educational consideration or treatment. The results appear in Table 6(b) (Appendix B, page 77) from which it will be seen that there is a large number of children with some defect of hearing requiring only special placing in a class and that 82 children with the use of hearing aids are making satisfactory progress in ordinary schools.

Many of the children attending special schools for partially deaf and deaf children go to the William Morris School for the Deaf in Walthamstow and during the coming year these children will have an audiometer test of their hearing and their progress will be carefully reviewed.

## **22. Delicate and Physically-handicapped Children**

The number of children newly ascertained as delicate (235) and the total numbers of delicate children in Day and Residential Special Schools, 228 and 101 respectively, in 1956, were the lowest for six years. The list of such children waiting for special accommodation rose again during the year owing to the closure of several schools outside the County, to which the Committee have in the past sent children. It is anticipated, however, that it will disappear when the Ogilvie School at Clacton-on-Sea is opened by the Committee in 1957.

The number of physically handicapped children newly ascertained was 46 which is also the lowest figure recorded since 1950, but in 1956 there were more physically-handicapped children placed in Special Schools than ever before and the waiting list for Special Schools dwindled to 24 (Table 5, page 75). There is in fact little delay in placing these children unless they suffer from cerebral palsy or more than one handicap.

The day schools which cater for delicate children and those which cater for the physically-handicapped are greatly changed in character, a fact which is referred to in the reports given below, in regard to the Open-Air School at Grays and the Wingfield House School for Physically-handicapped Children at Walthamstow.

### **OPEN AIR SCHOOL, GRAYS**

“During the year the usual remedial treatments were carried out.

These included extra rest, posture and breathing exercises, bar exercises and tipping for those children who were recommended to have them by the School Doctor at the regular weekly examinations. Almost all the children have also received regular daily doses of such medicines as were prescribed by the School Doctor, viz. Halibut Liver Oil, Multivite, Malt and Iron, Adexolin, Cod Liver Oil and Malt, Sulphex nasal drops or cough mixture. Two children attended local hospitals twice a week for therapeutic treatment. Six children had periods ranging from four to eight weeks in convalescent homes and eight had periods of in-patient treatment in hospital. One small boy suffering from fibrocystic disease of the pancreas died in Great Ormond Street Hospital in June.

Numbers have remained fairly constant throughout the year and at no time was there a waiting list. The number of boys again exceeded those of girls, particularly at the junior stage.

Attendances were fairly good despite the predisposition of many children to be sick through their particular disabilities. Seven children made perfect attendances during the Autumn term and nine others had only one day's absence. On the other hand there were four who made very few complete weeks' attendances. Excuses for absence were feeble and at times conflicting. One boy was discharged because of non-attendance.

Four children have been recommended for admission to a school for educationally sub-normal children and two others have been examined with that recommendation in view. One boy was recommended for admission to a residential school for educationally sub-normal pupils but his parents refused consent.

|                                                            | <i>Girls</i> | <i>Boys</i> | <i>Total</i> |
|------------------------------------------------------------|--------------|-------------|--------------|
| Number of children in attendance during course of the year | 48           | 63          | 111          |
| Number on register January, 1956                           | 37           | 51          | 88           |
| Number of admissions (including readmissions)              | 12           | 12          | 24           |
| Number of readmissions                                     | 1            | 2           | 3            |
| Number left during year                                    | 12           | 21          | 33           |
| Number on register December, 1956 (including four leavers) | 37           | 46          | 83           |

(The apparent discrepancy of 1 number on register January (88 + number of admissions 24=112, not 111) is caused by one child being discharged and re-admitted during the course of the year)

*Disposal of Leavers*

|                                                         | <i>Girls</i> | <i>Boys</i> | <i>Total</i> |
|---------------------------------------------------------|--------------|-------------|--------------|
| Fit to resume attendance at normal schools ....         | 7            | 14          | 21           |
| Removed from district ....                              | 1            | 3           | 4            |
| Fit to leave and of school leaving age ....             | 1            | —           | 1            |
| Discharged at parents' request ....                     | —            | 2           | 2            |
| Died ....                                               | —            | 1           | 1            |
| Discharged because of non-attendance ....               | —            | 1           | 1            |
| Admitted to Highwood Hospital ....                      | 1            | —           | 1            |
| Admitted to Clacton Residential Open-Air<br>School .... | 1            | —           | 1            |
| Admitted to Heathway E.S.N. School ....                 | 1            | —           | 1            |
|                                                         | 12           | 21          | 33           |

## WINGFIELD HOUSE SCHOOL FOR THE PHYSICALLY HANDICAPPED, WALTHAMSTOW

“ The average attendance during the year has been well up on the average of previous years, showing that the health of the children has been well maintained.

The children on roll at the end of the year were classified as follows:-

|                             |    |
|-----------------------------|----|
| Delicate ....               | 37 |
| Physically Handicapped .... | 49 |
| Epileptic ....              | 2  |

Twenty-four children were taken off the roll during the year of whom twelve were transferred to ordinary schools, three to schools for educationally sub-normal pupils, four to residential schools ; two left the district, one died, and two left to employment, both being placed satisfactorily in work. There were 27 admissions during the year.

There has been a distinct but subtle change in the type of case admitted to the school this being in keeping with the change of title from Hale End Open Air School to Wingfield House School. There are now no cases in the school of tuberculosis contacts or tuberculosis of the glands, and only one of tuberculosis in joints, and there are no cases of children suffering from malnutrition. The chief cause of referral is now mainly respiratory—asthma, bronchitis and bronchiectasis, and an increasing number of children suffering from nervous conditions aggravated by minor physical disabilities. This latter group are usually extremely backward educationally. A recent survey of intellectual assessment gave an I.Q. of 87 for 47 pupils in the school.

Three of the class-rooms have had their folding doors, which opened to the weather, replaced by conventional fixed walls with sash windows, giving the benefit of fresh air and sunshine in better weather and providing more adequate protection against draughts during cold inclement

weather. All class-rooms were decorated internally and externally during the summer.

The Chingford Jubilee Retreat Centre was used sporadically during the period May to September by all classes taking advantage of free activity in the Forest as the occasion arose.

During the Summer Holiday period the school was opened as usual on a voluntary basis, and an attendance of 91% was maintained. Visits were made to Thorpe Bay, Whipsnade Zoo, London Airport and to the Forest, which gave the period a home holiday flavour.

Dr. G. Poole, Deputy School Medical Officer, made regular weekly visits to the school and gave much helpful advice.

A total of 2,028 minor treatments have been given by the nursing staff at the school.

During the year public ambulances had to be used on 14 occasions to convey children home who had been taken ill during school hours.

Through the very helpful and valued co-operation with the local branch of the Invalid Children's Aid Association four children were sent away on convalescent holidays during the year.

The 'after care' of the more seriously physically handicapped boy or girl leaving school, and for whom there are few prospects of employment have been catered for by the strengthening of the existing 'After Care Association' to deal specifically with this type of case. Three ex-pupils from the school, one a recent case, are being visited and assisted by these means.

As in former years, swimming instruction was continued at the Technical College baths.

*Wingfield Music Club.* With the voluntary help of parents of the children attending the School and friends interested in music, under the aegis of Mr. Herbert Lyon, a Music Club was set in being last year with the twofold purpose of encouraging music both as an art and a therapy. Mr. Herbert Lyon, the Club Leader, ably assisted by friends, held a regular two hour session every Monday evening at the school. Free tuition and loan of instruments are available to interested physically handicapped persons—violin, cello, piano, recorder, double base, harmonica, flute and trumpet are taught in small groups and then combined together for orchestral purpose.

Several public performances have been given, and in December a film was made by the B.B.C. outside television unit for showing on Children's Television Hour.

Originally founded for the children at the School and for former pupils, the Club was opened to all in the area who are physically handicapped and interested in music. A Parent and Sympathisers' Association has been set up to strengthen the work of the Club, which has now grown beyond its original purpose. A one-handed girl cellist has had an audition for the National Youth Orchestra, and a violinist (severe asthma) has made good physical progress as her musical

capacity has improved, enabling her to pass successfully from Grade I to Grade III examinations of the Royal Associated Board.

Miss Vera Kantrovitch of the Trinity College of Music has taken a keen interest in the Club from its formation and has been elected President of the Club, which has now received generous help from many well-wishers in the area. It is felt that the results so far obtained justify an exploitation of the active participation in instrumental music as an adjunct to therapy in both physical and emotional aspects of disability."

### 23. Cerebral Palsied Children

Following the issue by the Ministry of Education in March, 1956 of Circular 300 (dealing with special educational treatment for physically handicapped children with special reference to those with cerebral palsy) a survey was made of the number of children in the County handicapped by this condition.

The result is detailed in Table 7 (Appendix B, page 78), from which it will be seen that there were 167 children of school age ascertained as handicapped on account of cerebral palsy. This gives an incidence of 0.6 per thousand children compared with a nation-wide incidence of 0.5 per thousand as estimated from the survey of physically handicapped children carried out by the Ministry of Education in 1951 (Health of the School Child 1952 and 1953). Some seven per cent of these children had been reported to the Committee under Section 57(3) as being ineducable. These statistics may under-estimate the real position since it appears that not all Divisions retained the names of these children on their lists of handicapped children after they had been reported.

Only 30 per cent of the children were sufficiently mobile and controlled to be able to attend ordinary schools. The greater number (96) were attending either special units for cerebral palsied children, open air schools, or schools for the physically handicapped whilst a few were attending other special schools on account of additional handicaps, e.g. deafness. Ten children were receiving home tuition; five of these were awaiting suitable placement in special schools. There were only 23 children at residential special schools, 15 of whom came from rural Divisions.

One of the reasons for undertaking the survey was to estimate the need for small day units where combined facilities for therapy and education could be arranged particularly for children, who for geographical reasons were having to be taught in residential schools or at home. It appeared that 29 children of school age were likely to benefit from the provision of such units, but 25 children were already attending special cerebral palsy units at Ilford and in West Ham.

The needs of children aged 2-5 must also be considered because cerebral palsy is a condition in which intensive therapy and wise handling when a child is young can prevent the almost inevitable handicap from being severe, and can often restrict incapacity to a minimum. There were 29 pre-school children known to Divisional School Medical Officers as having cerebral palsy at the time of the survey. Only one of these children was attending a cerebral palsy unit (at West Ham) and of the remaining 28 it was thought that six would have benefited from similar provision had it been available.

It would therefore appear that the demand for further special units exists so far as six pre-school children and four children of school age are concerned. These figures should, however, be treated with reserve ; it is significant that where there is a special unit in existence the incidence of cerebral palsy works out at something like 1.2 per 1,000 school children, and that in those Divisions where facilities for special educational treatment are available the incidence tends to be greater than in the Divisions where no such facilities exist ; in the Forest Division for instance, where the National Spastics Society have a treatment centre for children of all ages, there are 16 children of pre-school age with cerebral palsy. This may indicate as is often the case that the real size of the demand is not fully revealed until facilities for treatment are first available.

The Ministry of Education suggested that the establishment of special day units for cerebral palsied children might satisfactorily cater for as few as 10 children of all ages but considered that one of the basic requirements was a steady demand. At the time of the survey, the four children of school age who it was thought might benefit from a special day unit were scattered throughout South and South East Essex and there is therefore insufficient justification at present for the establishment of any more units in Essex. The need for facilities for a pre-school group in connection with the existing unit at Ilford is still under consideration.

## 24. Maladjusted Children

It is not surprising that the increasing number of children dealt with at the Child Guidance Clinics also resulted in an increase in the number of children requiring special educational treatment on account of maladjustment. Ninety-six children were newly ascertained during the year as requiring such treatment and the total number of children on the registers of special schools, independent schools and boarding homes is still considerably more than it was five years ago—221 compared with 140 (Table 5, page 75).

It is interesting to note that five years ago 83 children were at independent schools under arrangements made by the Committee and that last year 84 children were similarly placed. It is unlikely that there will be much alteration in this figure ; there will always be a small number of children who show early evidence of maladjustment which will require lengthy periods of relief from an irritating home environment, in which parents can be said to be primarily responsible for the child's maladjustment.

These are the cases in which treatment of the parents is important during the school term as a necessary preliminary in preparing them to receive the child when he is ready for discharge from the boarding school.

In order that this treatment may be effective very close liaison is necessary between Child Guidance Clinics, the school and the home. Dr. Susannah Davidson (Ilford) described an effort to forge this link :—

“A visit was made by several members of the staff to “ The Homestead ” at Langham, and we hope to visit Nazeing Park shortly. Mr. Sheward has visited us, and we have had full discussions with him over

all the cases we have sent to him from this Clinic. It has given us ample evidence of the enormous value of close contact between the school and Clinic. Our Psychiatric Social Workers do a great deal of work with the families of children we have treated and who are now in Residential Schools, and have done much to prevent parents removing the children from the schools prematurely, and in helping the parents to be able to accept the child back home again."

Table 5 shows that 114 children were resident in special schools for maladjusted children, a number that has trebled during the last five years. This is partly to be accounted for by the fact that the Committee opened a school for maladjusted children of junior age at Nazeing in 1952 and the Homestead School, Langham, for maladjusted senior boys in 1956. Eighty-three children were placed in 1956 compared with 61 in 1955, but owing to the increasing demand the waiting list is still steadily increasing and is now 41.

Excellent work is still being achieved at the Nazeing School. After an average stay of  $2\frac{1}{2}$  years, 25%, of the children have been able to return to their homes and attend ordinary school, but it is disappointing that an equal percentage of children is still not suitably placed, as is shown by the following report of Dr. Helen Gillespie, the Consultant Psychiatrist to the School :—

"Two full day visits were made each month and the work of the Psychiatrist continued on the same lines as in previous years. Ten children were kept under regular psychiatric supervision. On the whole the children appeared to form a well integrated group whose members exert a therapeutic influence on each other ; those children who have already gained insight into their own difficulties helping their more perplexed companions to a better understanding of the aims and advantages of the community in which they now find themselves. It is most heartwarming to see the trust and affection the children show to the staff and to see their tensions relaxing in the congenial and secure environment of the school.

In the five years that the school has been open, forty-four children have left, the average stay being 2 years and 5 months. The following is an account of their disposal :—

|                                                                                                                               | <i>Boys</i> | <i>Girls</i> |
|-------------------------------------------------------------------------------------------------------------------------------|-------------|--------------|
| Living at home and attending day school as recommended ....                                                                   | 5           | 5            |
| Other residential placement recommended but not implemented because of the refusal of the parents or the local authority .... | 4           | 5            |
| At normal boarding schools as recommended ....                                                                                | 6           | 2            |
| In hostels and attending day school ....                                                                                      | 4           | —            |
| In residential E.S.N. schools as recommended ....                                                                             | 2           | 2            |
| At senior schools for maladjusted pupils as recommended ....                                                                  | 5           | 3            |
| At approved school ....                                                                                                       | —           | 1            |

It follows from the above that not all these children when they reach the age of 11+ are ready for discharge to their homes and ordinary day school. In most cases the environmental difficulties are unmodifiable or the child simply has no home of his own to go to. It is to be remembered that when these children leave our school at the age of eleven, they have still to face the stresses of puberty, which in such unstable subjects are particularly liable to produce further serious difficulties, including anti-social behaviour. In cases where this seems likely to happen, it would obviously be better for them to remain in a residential school for the maladjusted after the age of eleven, in order to insure that they are handled with skill and understanding.

My visits to Nazeing Park and the discussions I had there with Mr. Sheward, the Headmaster, have impressed on me that it will be very helpful to the staff if visits could be organised of persons having wide experience in the field of maladjustment, who could hold discussions and seminars with the staff members. In a place like Nazeing, the staff are necessarily somewhat isolated and in need of such stimulating contacts with fresh ideas and methods of approach. I have no doubt that if such visits could be arranged the effect would be most valuable, both in encouraging the staff in their difficult and often trying tasks, and raising the level of their work, good though that already is. It should be remembered in this connection that some members of a staff at schools for the maladjusted have not had the benefit of any special training in this specialised educational field.

I very much hope that it may be possible to give effect to this suggestion."

In discussing the future of the children at Nazeing who reach the age of 11, Dr. Gillespie touches the fringe of a problem which has been experienced to a greater degree at the new school for senior boys at Langham. Dr. H. N. Davy, Consultant to the school, writes :—

"On the opening day, 28th May, 1956, I was present and met several of the boys and their parents together with the members of the staff. There were eighteen boys during this first half-term, and by August, 1956, a community spirit was developing. Unfortunately, three very disturbed children were admitted on 9th July, 22nd August and 1st October, 1956, who nearly succeeded in wrecking the school. Before considering this point of suitable cases for admission, I will indicate the general problem.

I considered the most economical use of my three hours each fortnight was to be always on hand to discuss any problems that the Headmaster, Mr. Kenneth Cowling, and his staff, encountered among the boys. It was manifestly impossible to give individual psychiatric treatment for eighteen or thirty-seven new boys during these first and second terms. I saw those individuals who presented such medical and psychological problems to the staff, and the others were discussed in staff conferences.

The second term, on 3rd September, started with a sudden influx of eleven boys. This, in retrospect, seems to have been an error because the new admissions, together with these three very disturbed boys, broke up the community feeling which had begun to develop during the first term.

At the Inter-Child Guidance Clinic Conference, held at Chelmsford on 9th June, I warned the Clinics against referring impossibly difficult problem children to the newly opened school during the initial period, in particular boys who have been tried out in previous 'Junior Schools for Maladjusted Boys.' For example, some who have been to 'Nazeing' after returning home and failing to be acceptable to the home have been transferred to "Homestead," and they have come with resentment. There are also some seriously disturbed anti-social and near-psychotic children who are incapable of fitting into a community life. Two or three such boys disrupted the whole academic curriculum and by their grossly abnormal conduct and attacks of violence, upset the less stable boys who had previously settled in. They raised problems of individual supervision and made impossible demands on the very limited staff. One of these boys had to be removed from a very experienced School for Maladjusted Children, and is now about to be admitted to The Maudsley Psychiatric Hospital. Another had been previously described in a Classifying School as "pre-psychotic." The third, who came to the School after six months in a Hospital Unit, has had to be readmitted to a Psychiatric Ward for neurological investigations and, I hope, for appropriate medical treatment.

Mr. D. F. Ward, the Educational Psychologist and I attended the Staff Conferences during the crises that followed these boys' behaviour; we felt that it was useful for the staff to be able to discuss these critical situations that must inevitably arise in a school for maladjusted children.

I think that unfair comparisons can be made between the problems of the Junior School for Maladjusted such as Nazeing (seven to eleven years) and those of a Senior School where the ages range, in effect, from extreme immaturity up to fifteen years, particularly when the fifteen-year-old is well past puberty and has interests, physical development and needs which put him in a class apart from the main body of children whose most striking characteristic is that they look so much younger than their chronological ages. Possibly in a year's time, when the staff have had more experience, it will be able to tackle some of the more difficult problems, but a staff of five teachers cannot be expected to cope with the educational needs, dormitory duties, three separate evening hobby groups, twenty-four-hourly supervision, seven days a week, plus such extremely disturbed boys.

At the recent meetings in London, the view was expressed that the staff ratio for these very disturbed children should be in the neighbourhood of one to one, or one to two—as in a special observation or in-patient unit.

I hope that, in the future, we shall be able to be more careful in our admissions. The selection of suitable boys to be admitted at any one time depends, in the first place, on the ability of the staff to cope with that problem ; or whether the community spirit is strong enough to take in its stride a certain type of problem (i.e. a batch of two more anti-social boys, prone to aggressive violence and suicidal attempts) ; and on adequate medical and sociological information being made available to the informal Selecting Committee before admission, not afterwards. It follows that the Headmaster's view, the Educational Service view and the medical aspects need each to be represented in an informal Selecting Committee to decide re-admissions."

## 25. Educationally Sub-normal Children

The number of children who were newly ascertained as educationally sub-normal during 1956 was 348. A record number of 242 children was also newly placed in schools for educationally sub-normal, probably as a result of the opening of the new day school at Corbets Tey, Upminster in September, and the re-opening of Hassobury School in June. However, the number of children awaiting suitable placement at the end of the year remains practically the same as a year ago. The position in this respect in the rural Divisions is particularly acute. Efforts are being made to meet the need by the use of "retarded classes" as in Clacton-on-Sea and peripatetic remedial teachers as in the Mid-Essex Division but as Dr. John D. Kershaw (North East Essex) points out :—

"Boarding Special Schools are the only present hope for these children and occasionally parents are very reluctant to let their children leave home."

Unfortunately it is the Boarding Schools which have particularly long waiting lists.

## 26. Epileptic Children

Following the publication of Circular 10/56, in January, 1956, in which the Ministry of Health drew attention to the recommendations contained in a report on the Medical Care of Epileptics made by a Sub-Committee of the Minister's Standing Medical Advisory Committee, an opportunity was taken to review the placement of children ascertained as handicapped on account of epilepsy.

These results appear in full in Table 8 (Appendix B, page 79), and it will be seen that the incidence of epilepsy in school children throughout the County is 0.8 per thousand children, compared with 1.2 per thousand recorded in a Ministry of Education survey in 1950 (Health of the School Child, 1950 and 1951). The total number of school children with epilepsy was 214. The great majority (70%) were being educated in ordinary schools (as recommended by the Sub-Committee) and to this extent, epilepsy in school children does not present a major problem. It is important, however, when epileptic children are sent to ordinary schools that School Medical Officers should ensure that

teachers are sufficiently acquainted with the condition and are confident that they can manage the child and the class when a fit occurs. No epileptic child should be admitted to an ordinary school without prior discussion with the teacher.

Of the remainder, 32 were receiving care and attention in epileptic colonies and 37 were in other special schools or receiving home tuition. Eight children were under medical treatment at home or in hospital.

The incidence of behaviour disorders amongst all these children is not known, but during the year there have been a few children with such severe disorders of this description that schools for maladjusted children have not been able to manage them satisfactorily and they have therefore been a real problem so far as placement is concerned.

One of the main recommendations of the Sub-Committee which has advised the Minister is that hospitals should be encouraged to provide diagnostic and treatment clinics for epileptics. It will obviously be in the interests of children suffering from this condition that School Medical Officers should establish a very close liaison with these clinics when they are provided.

## REPORT OF THE PRINCIPAL SCHOOL DENTAL OFFICER

for the Year 1956

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### Staff

At the end of the year the number of dental officers in post not including the Principal School Dental Officer was 26 whole-time and 47 part-time and sessional officers giving an equivalent whole-time total of 44.3 compared with 42.7 at the corresponding date last year. The staff continues to give part-time service to patients referred from the maternity and child welfare clinics and thus the effective time available for the treatment of school children is reduced by about one eleventh. "The aim of the School Dental Service should be to ensure that so far as possible children shall leave school without the loss of permanent teeth, free from dental disease and irregularity, and trained in the care of the teeth." This is a quotation from the latest report of the Chief Medical Officer of the Ministry of Education in the "Health of the School Child." We are a long way from attaining that end in spite of repeated efforts to obtain more staff. Advertising for dental officers in a variety of journals and newspapers has produced practically no interest even with the possibility of extra evening sessional work and, in the new towns of Harlow and Basildon, housing accommodation. Personal contact has been made with practitioners with no result. The personal service of dentistry to be at its best, demands continuity of treatment by the same professional and ancillary staffs. Constant change is disturbing, especially to young children and as in other branches of dentistry the art of practice building is necessary for the successful running of a local authority clinic. The number of appointments and resignations of dentists occurring during the year was 61, and this remarkable figure is not reached without repercussion on the Service. The administrative problems too are magnified. The problem of recruitment is a national one, but tends to be acute in places like Essex on account of the rapidly expanding population. The demand for general dental service is such that new practitioners who could normally be expected to give part-time service to the authority over a fairly long period, find that in a short time they are fully employed at their own surgeries where remuneration is much better. There is little doubt that the reason for the staffing difficulty is an economic one.

It is with regret that I record the loss to the Service at the end of the year of Mr. L. W. Elmer who has served the Borough of Walthamstow and the County Council since 1932 as Senior Dental Officer. I wish him many years of happy retirement.

### Premises and Equipment

All new dental suites are equipped with comprehensive up-to-date equipment and the policy to re-equip the older premises has been pursued steadily during the year. The difference in the appearance, comfort and working

efficiency between modern purpose built and adapted premises is to be seen to be believed. It should be axiomatic that the premises and equipment of the local authority service are such as will raise no invidious comparison with other branches of the profession.

### Statistics

During 1956, 45,894 children received treatment compared with 41,154 in 1955, but the ratio of the number of teeth filled to the number of teeth extracted has fallen from 1.3 to 1.2. The interpretation of this must be that more time has been allotted of necessity to extraction for the relief of pain and less to the conservation of the teeth. This is a vicious circle which can only be broken by more staff.

### Orthodontics

In July, 1955, the Ministry of Education Circular 288 and the Ministry of Health Circular-M. (55) 67 regarding orthodontics were received. The responsibility for providing a consultant service in this highly specialised branch of dentistry and for providing treatment for the more complex cases of irregular teeth now rests with the appropriate Regional Hospital Boards. Contact has been made with the North East Metropolitan and the East Anglian Regional Hospital Boards but nothing has yet transpired which is of assistance to the School Dental Service. In some authorities specially experienced officers carry out orthodontic treatment for complex cases and offer advice to the staffs on treatment of more simple cases and some authorities employ practitioners of consultant rank. The teaching schools are also available to a limited extent to assist but, of course, their main concern is undergraduate instruction. In Essex use is made of the teaching schools, and some of the divisions have dentists specially experienced in orthodontics, and here it should be said that no extra remuneration is given for this work as yet. There is a big demand for this form of dental treatment and the results are sometimes most spectacular. Constant review is necessary to ensure that only a reasonable proportion of available dental officer time is given to the work ; 944 cases were completed during the year.

### General Anaesthetics

Following the policy that only a selected small number of Assistant County Medical Officers or visiting general medical practitioners should be responsible for the administration of general anaesthetics in each division, permission has been obtained for a number of doctors to attend post graduate courses at the Eastman Dental Hospital. In addition a few have also attended the dental out-patient clinic at Guys Hospital to observe the routine adopted at a busy clinic. These courses are being continued until all the assistant medical officers designated have attended. There are isolated cases where other anaesthetics than nitrous oxide (dental gas) may be indicated and which may be undertaken

with confidence by expert anaesthetists. In this respect it is noted that the Minister of Education is now not averse to an anaesthetic other than nitrous oxide being used in selected cases by a competent anaesthetist. The arrangement whereby a consultant of the North East Metropolitan Regional Hospital Board attends Walthamstow has been continued and his services have been extended to include Romford.

### **Post Graduate Instruction**

The policy has been established that the full-time dental officers may attend post graduate courses on children's dentistry and several of the staff have attended the Eastman Dental Hospital during the year for a week's course.

### **Dental Appliances**

The dental laboratories at Barking and Walthamstow continue to be fully occupied making orthodontic appliances and dentures for the school and maternity and child welfare services. Most of the work done at Walthamstow is for that district but the Barking laboratory caters for places further afield. It is incumbent on the local authority to make or procure appliances needed in the Executive Council Dental Service at the Health Centres at Harold Hill and Aveley—the Barking laboratory covers this demand. During the year some alteration has been made to the administration of this laboratory with a resulting quicker turn-round of work. More work is being let out to mechanics to the profession and the Health Committee has agreed in principle to the need for a further laboratory. 303 dentures and 927 orthodontic appliances have been made during the year, together with a large number of dentures for expectant and nursing mothers.

### **School Inspections**

Efforts should be directed to undertake inspections on school premises. The practice of relying for a full supply of patients from children attending clinics casually, is to be deprecated. It is necessary for the staff to keep the initiative as to whom will be offered full treatment and this is best done by routine school inspections.

### **Treatment**

The shortage of staff inevitably brings the need for judicious screening by dental officers in their offers of conservation treatment. Children whose parents intermittently refuse treatment and children who show a lack of oral hygiene are generally less likely to benefit from routine dental treatment than are other classes of children. Fillings in the deciduous dentition should be undertaken only after due deliberation. It is acknowledged that the premature loss of deciduous teeth may lead in some cases to irregularity of the permanent teeth, but there is no doubt whatever that neglect of the permanent teeth will be followed by dentures and the moral is obvious. However, every effort should

be made to offer treatment to children who have had teeth filled during their pre-school years. Pre-school children should have a school treatment chart which would be transferred to the school files at the appropriate time. It is pertinent to remark here that a purchase tax is still payable on dental record charts.

The incidence of dental decay shows no signs of decreasing but the dental manpower on the other hand may be expected to decrease during the next year or so as dentists take advantage of the National Health Service Act Superannuation Regulations which become operative in 1958. One is therefore forced to look elsewhere for some amelioration of our problems. It is encouraging to see that the Ministry of Health is pressing forward with its scheme of adding fluorine to the water supply and that this has already been begun in several selected places. There is ample evidence that the addition of sodium fluoride to the domestic water supply to bring up the content to about 1 p.p.m. has a beneficial effect on the caries resisting qualities of the teeth and this without any observable side effects. The policy is a long term one, because to get the full benefit for the child, the expectant mother should use the fluoridated water. Care of the teeth and a consciousness of the need for oral hygiene have a beneficial effect and a campaign of dental health education could have desirable results. We were fortunate to have Miss E. M. Knowles, F.D.S., a senior Dental Officer of the Ministry of Health, at the County Hall in December to address the Dental and Medical Officers and also the Health Visitors and Dental Attendants, and we were grateful for her interest in this matter. A considerable part of the dental officers' time is given to the preservation of the first permanent molar teeth, which are very prone to rapid decay and the time is overdue for a properly conducted investigation into the results of the extraction of these teeth from the upper or lower jaws or both as the case may indicate. There is no doubt that this form of treatment in some cases gives very good results, overcrowding of the teeth being avoided and much subsequent decay averted. There must be a wealth of information and experience if only it could be co-ordinated and used as a preliminary to research in the type of case suitable and the correct timing of the extractions.

The report of the Committee on recruitment to the dental profession (McNair report) makes some unpleasant reading and underlines the present shortage of dentists and shows the futility of expecting an early solution to our problems.

The most important event in the dental calendar for 1956 was the Royal assent to the Dentists Bill in March and its becoming operative on the 4th July. The Act establishes a General Dental Council with full disciplinary powers over the profession and with a ruling over the education and examinations of dental undergraduates. So far as those associated with the public dental service are concerned, an important part of the Act provides for the establishment by way of experiment of a new class of ancillary dental worker somewhat similar to the dental nurses of New Zealand. The Act lays down that the regulations governing this class of ancillary shall not undertake (a) the extraction of teeth other than deciduous teeth, (b) the filling of teeth or the extraction of deciduous teeth,

except in the provision of National and Local Health Service, (c) the fitting of dentures. The General Dental Council is authorised to make arrangements for the experimental training of a number of these ancillary workers for work in the Local and National Services. After qualification, these persons will work under the direction of a registered dentist who must first examine the patient, and prescribe the treatment to be carried out. As the course of training will probably be of about two years' duration it appears that several years will elapse before the results of the experiment will be known.

Those who have been many years in the Local Authority Dental Service have seen an almost complete reversal of public opinion to the conservation of the natural teeth. Some dental officers remember the time when the offer to fill teeth was met by a blank refusal at the least. Now people are demanding this form of treatment and there is not sufficient staff to cope with the demand—the wheel has turned full circle.

J. BYROM.

## APPENDIX A

## MEDICAL INSPECTION AND TREATMENT RETURNS

YEAR ENDED 31ST DECEMBER, 1956

Table 1

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY  
AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS).*A.—Periodic Medical Inspections.*

## (1) Number of Children examined :—

|                    |      |      |      |      |      |      |      |        |
|--------------------|------|------|------|------|------|------|------|--------|
| 5 years            | .... | .... | .... | .... | .... | .... | .... | 25,933 |
| 10—12 (plus) years | .... | .... | .... | .... | .... | .... | .... | 28,070 |
| 14 years           | .... | .... | .... | .... | .... | .... | .... | 15,553 |

|       |      |      |      |      |      |      |      |        |
|-------|------|------|------|------|------|------|------|--------|
| Total | .... | .... | .... | .... | .... | .... | .... | 69,556 |
|-------|------|------|------|------|------|------|------|--------|

|                                     |      |      |      |      |      |      |      |       |
|-------------------------------------|------|------|------|------|------|------|------|-------|
| (2) Additional Periodic Inspections | .... | .... | .... | .... | .... | .... | .... | 7,624 |
|-------------------------------------|------|------|------|------|------|------|------|-------|

|             |      |      |      |      |      |      |      |        |
|-------------|------|------|------|------|------|------|------|--------|
| Grand Total | .... | .... | .... | .... | .... | .... | .... | 77,180 |
|-------------|------|------|------|------|------|------|------|--------|

*B.—Other Inspections.*

|                               |      |      |      |      |      |      |      |        |
|-------------------------------|------|------|------|------|------|------|------|--------|
| Number of Special Inspections | .... | .... | .... | .... | .... | .... | .... | 36,165 |
|-------------------------------|------|------|------|------|------|------|------|--------|

|                          |      |      |      |      |      |      |      |        |
|--------------------------|------|------|------|------|------|------|------|--------|
| Number of Re-inspections | .... | .... | .... | .... | .... | .... | .... | 37,544 |
|--------------------------|------|------|------|------|------|------|------|--------|

|       |      |      |      |      |      |      |      |        |
|-------|------|------|------|------|------|------|------|--------|
| Total | .... | .... | .... | .... | .... | .... | .... | 73,709 |
|-------|------|------|------|------|------|------|------|--------|

*C.—Number of Individual Pupils found at Periodic Medical Inspection to  
Require Treatment (excluding Dental Diseases and Infestation with  
Vermin).*

| Group<br>(1)                    |      |      | For defective<br>vision (excluding<br>squint)<br>(2) |      | For any of the<br>other conditions<br>recorded in<br>Table III<br>(3) |      | Total<br>individual<br>Pupils<br>(4) |
|---------------------------------|------|------|------------------------------------------------------|------|-----------------------------------------------------------------------|------|--------------------------------------|
| 5 years                         | .... | .... | 522                                                  | .... | 3,325                                                                 | .... | 3,707                                |
| 10—12 (plus) years              | .... | .... | 1,675                                                | .... | 3,204                                                                 | .... | 4,614                                |
| 14 years                        | .... | .... | 943                                                  | .... | 1,313                                                                 | .... | 2,144                                |
| Total                           | .... | .... | 3,140                                                | .... | 7,842                                                                 | .... | 10,465                               |
| Additional Periodic Inspections | .... | .... | 540                                                  | .... | 1,095                                                                 | .... | 1,550                                |
| Grand Total                     | .... | .... | 3,680                                                | .... | 8,937                                                                 | .... | 12,015                               |

D.—CLASSIFICATION OF THE PHYSICAL CONDITION OF PUPILS INSPECTED  
IN THE AGE GROUPS RECORDED IN TABLE 1.A.

| <i>Age Groups Inspected</i><br>(1) | <i>Number<br/>of Pupils<br/>Inspected</i><br>(2) | <i>Satisfactory</i> |                                 | <i>Unsatisfactory</i> |                                 |
|------------------------------------|--------------------------------------------------|---------------------|---------------------------------|-----------------------|---------------------------------|
|                                    |                                                  | <i>No.</i><br>(3)   | <i>% of<br/>Col. (2)</i><br>(4) | <i>No.</i><br>(5)     | <i>% of<br/>Col. (2)</i><br>(6) |
| 5 years                            | 25,933                                           | 25,075              | 96.7                            | 858                   | 3.3                             |
| 10—12 + years                      | 28,070                                           | 27,163              | 96.8                            | 907                   | 3.2                             |
| 14 years                           | 15,553                                           | 15,414              | 99.1                            | 139                   | 0.9                             |
| Additional Periodic<br>Inspections | 7,624                                            | 7,216               | 94.6                            | 408                   | 5.4                             |
| Total                              | 77,180                                           | 74,868              | 97.0                            | 2,312                 | 3.0                             |

Table II

INFESTATION WITH VERMIN

|                                                                                                                          |         |
|--------------------------------------------------------------------------------------------------------------------------|---------|
| (1) Total number of individual examinations of pupils in the schools<br>by the school nurses or other authorised persons | 548,749 |
| (2) Total number of <i>individual</i> pupils found to be infested                                                        | 1,569   |
| (3) Number of individual pupils in respect of whom cleansing<br>notices were issued (Section 54(2), Education Act, 1944) | 26      |
| (4) Number of individual pupils in respect of whom cleansing<br>orders were issued (Section 54(3), Education Act, 1944)  | 11      |

Table III

RETURN OF DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR  
ENDED 31ST DECEMBER, 1956.

## A. PERIODIC INSPECTIONS

| Defect<br>Code<br>No. | Defect or Disease     | PERIODIC INSPECTIONS             |                                    |                                  |                                    | TOTAL<br>(Including all other<br>age groups<br>inspected) |                                    |
|-----------------------|-----------------------|----------------------------------|------------------------------------|----------------------------------|------------------------------------|-----------------------------------------------------------|------------------------------------|
|                       |                       | Entrants                         |                                    | Leavers                          |                                    | Requir-<br>ing<br>Treat-<br>ment                          | Requir-<br>ing<br>Observa-<br>tion |
|                       |                       | Requir-<br>ing<br>Treat-<br>ment | Requir-<br>ing<br>Observa-<br>tion | Requir-<br>ing<br>Treat-<br>ment | Requir-<br>ing<br>Observa-<br>tion |                                                           |                                    |
| (1)                   | (2)                   | (3)                              | (4)                                | (5)                              | (6)                                | (7)                                                       | (8)                                |
| 4                     | Skin ....             | 196                              | 365                                | 268                              | 233                                | 1,035                                                     | 1,014                              |
| 5                     | Eyes—                 |                                  |                                    |                                  |                                    |                                                           |                                    |
|                       | (a) Vision ....       | 529                              | 1,113                              | 1,114                            | 507                                | 3,680                                                     | 2,757                              |
|                       | (b) Squint ....       | 253                              | 230                                | 39                               | 26                                 | 445                                                       | 416                                |
|                       | (c) Other ....        | 83                               | 102                                | 43                               | 76                                 | 281                                                       | 347                                |
| 6                     | Ears—                 |                                  |                                    |                                  |                                    |                                                           |                                    |
|                       | (a) Hearing....       | 83                               | 340                                | 34                               | 85                                 | 240                                                       | 645                                |
|                       | (b) Otitis Media .... | 59                               | 313                                | 28                               | 51                                 | 120                                                       | 508                                |
|                       | (c) Other ....        | 132                              | 85                                 | 78                               | 26                                 | 384                                                       | 184                                |
| 7                     | Nose and Throat ....  | 748                              | 2,267                              | 90                               | 227                                | 1,290                                                     | 3,494                              |
| 8                     | Speech....            | 226                              | 428                                | 13                               | 43                                 | 315                                                       | 673                                |
| 9                     | Lymphatic Glands .... | 53                               | 727                                | 4                                | 59                                 | 86                                                        | 1,168                              |
| 10                    | Heart ....            | 71                               | 332                                | 41                               | 169                                | 185                                                       | 846                                |
| 11                    | Lungs ....            | 218                              | 696                                | 49                               | 173                                | 493                                                       | 1,467                              |
| 12                    | Developmental—        |                                  |                                    |                                  |                                    |                                                           |                                    |
|                       | (a) Hernia ....       | 53                               | 125                                | 4                                | 6                                  | 80                                                        | 188                                |
|                       | (b) Other ....        | 61                               | 477                                | 36                               | 115                                | 236                                                       | 1,081                              |
| 13                    | Orthopædic—           |                                  |                                    |                                  |                                    |                                                           |                                    |
|                       | (a) Posture ....      | 143                              | 198                                | 180                              | 229                                | 811                                                       | 897                                |
|                       | (b) Feet ....         | 388                              | 480                                | 126                              | 118                                | 1,060                                                     | 1,082                              |
|                       | (c) Other ....        | 437                              | 708                                | 191                              | 279                                | 1,092                                                     | 1,760                              |
| 14                    | Nervous system—       |                                  |                                    |                                  |                                    |                                                           |                                    |
|                       | (a) Epilepsy ....     | 12                               | 36                                 | 4                                | 8                                  | 33                                                        | 105                                |
|                       | (b) Other ....        | 19                               | 115                                | 7                                | 47                                 | 61                                                        | 339                                |
| 15                    | Psychological—        |                                  |                                    |                                  |                                    |                                                           |                                    |
|                       | (a) Development ....  | 24                               | 197                                | 12                               | 23                                 | 127                                                       | 407                                |
|                       | (b) Stability ...     | 83                               | 425                                | 15                               | 80                                 | 209                                                       | 965                                |
| 16                    | Abdomen ....          | 10                               | 75                                 | 6                                | 26                                 | 31                                                        | 192                                |
| 17                    | Other ....            | 417                              | 149                                | 190                              | 75                                 | 1,157                                                     | 475                                |

Table III (Continued)

## B. SPECIAL INSPECTIONS

| Defect<br>Code<br>No.<br>(1) | Defect or Disease<br>(2) | Special Instructions       |                              |
|------------------------------|--------------------------|----------------------------|------------------------------|
|                              |                          | Requiring Treatment<br>(3) | Requiring Observation<br>(4) |
| 4                            | Skin ....                | 3,620                      | 137                          |
| 5                            | Eyes—                    |                            |                              |
|                              | (a) Vision ....          | 961                        | 513                          |
|                              | (b) Squint ....          | 59                         | 20                           |
|                              | (c) Other ....           | 677                        | 114                          |
| 6                            | Ears—                    |                            |                              |
|                              | (a) Hearing ...          | 211                        | 121                          |
|                              | (b) Otitis Media ...     | 96                         | 39                           |
|                              | (c) Other ....           | 255                        | 25                           |
| 7                            | Nose and Throat ....     | 1,010                      | 348                          |
| 8                            | Speech ....              | 428                        | 130                          |
| 9                            | Lymphatic Glands ....    | 44                         | 37                           |
| 10                           | Heart ....               | 66                         | 62                           |
| 11                           | Lungs ....               | 241                        | 189                          |
| 12                           | Developmental—           |                            |                              |
|                              | (a) Hernia....           | 7                          | 8                            |
|                              | (b) Other ....           | 90                         | 72                           |
| 13                           | Orthopædic—              |                            |                              |
|                              | (a) Posture ....         | 73                         | 50                           |
|                              | (b) Feet ....            | 234                        | 82                           |
|                              | (c) Other ....           | 1,250                      | 207                          |
| 14                           | Nervous System—          |                            |                              |
|                              | (a) Epilepsy ....        | 16                         | 16                           |
|                              | (b) Other ....           | 135                        | 129                          |
| 15                           | Psychological—           |                            |                              |
|                              | (a) Development ....     | 124                        | 63                           |
|                              | (b) Stability ....       | 177                        | 88                           |
| 16                           | Abdomen ....             | 54                         | 21                           |
| 17                           | Other ....               | 4,532                      | 851                          |



*Group 4.—Diseases of the Skin (excluding Uncleanliness, for which see Table II)*

|                     | Number of cases treated<br>or under treatment<br>during the year |      |      |      |      |       |
|---------------------|------------------------------------------------------------------|------|------|------|------|-------|
| Ringworm—           |                                                                  |      |      |      |      |       |
| (i) Scalp           | ....                                                             | .... | .... | .... | .... | 5     |
| (ii) Body           | ....                                                             | .... | .... | .... | .... | 13    |
| Scabies             | ....                                                             | .... | .... | .... | .... | 20    |
| Impetigo            | ....                                                             | .... | .... | .... | .... | 323   |
| Other skin diseases | ....                                                             | .... | .... | .... | .... | 5,427 |
| Total               | ....                                                             | .... | .... | .... | .... | 5,788 |

*Group 5.—Child Guidance Treatment*

|                                                                                                |      |      |      |     |
|------------------------------------------------------------------------------------------------|------|------|------|-----|
| Number of pupils treated at Child Guidance Clinics<br>under arrangements made by the Authority | .... | .... | .... | 833 |
|------------------------------------------------------------------------------------------------|------|------|------|-----|

*Group 6.—Speech Therapy*

|                                                                                           |      |      |      |       |
|-------------------------------------------------------------------------------------------|------|------|------|-------|
| Number of pupils treated by Speech Therapists under<br>arrangements made by the Authority | .... | .... | .... | 2,914 |
|-------------------------------------------------------------------------------------------|------|------|------|-------|

*Group 7.—Other Treatment Given*

|                                                                                            |      |      |      |      |      |        |
|--------------------------------------------------------------------------------------------|------|------|------|------|------|--------|
| (a) Number of cases of miscellaneous minor ailments treated by<br>the Authority            | .... | .... | .... | .... | .... | 9,785  |
| (b) Pupils who received convalescent treatment under School<br>Health Service arrangements | .... | .... | .... | .... | .... | 624    |
| (c) Pupils who received B.C.G. vaccination                                                 | .... | .... | .... | .... | .... | 8,183  |
| (d) Other than (a), (b) and (c) above                                                      |      |      |      |      |      |        |
| 1. Enuresis                                                                                | .... | .... | .... | .... | .... | 137    |
| Total (a)—(d)                                                                              | .... | .... | .... | .... | .... | 18,729 |

**Table V**

**DENTAL INSPECTION AND TREATMENT**

|                                                                    |      |      |      |      |      |        |
|--------------------------------------------------------------------|------|------|------|------|------|--------|
| (1) Number of pupils inspected by the Authority's Dental Officers— |      |      |      |      |      |        |
| (a) At Periodic Inspections                                        | .... | .... | .... | .... | .... | 71,352 |
| (b) As specials                                                    | .... | .... | .... | .... | .... | 24,854 |
| Total                                                              | .... | .... | .... | .... | .... | 96,206 |

|       |                                                       |      |      |      |      |         |
|-------|-------------------------------------------------------|------|------|------|------|---------|
| (2)   | Number found to require treatment                     | .... | .... | .... | .... | 66,374  |
| (3)   | Number offered treatment                              | .... | .... | .... | .... | 57,999  |
| (4)   | Number actually treated                               | .... | .... | .... | .... | 45,894  |
| (5)   | Attendances made by pupils for treatment              | .... | .... | .... | .... | 128,140 |
| <hr/> |                                                       |      |      |      |      |         |
| (6)   | Half days devoted to—                                 |      |      |      |      |         |
|       | Periodic Inspection                                   | .... | .... | .... | .... | 1,048   |
|       | Treatment                                             | .... | .... | .... | .... | 16,546  |
|       | Total                                                 | .... | .... | .... | .... | 17,594  |
| <hr/> |                                                       |      |      |      |      |         |
| (7)   | Fillings—                                             |      |      |      |      |         |
|       | Permanent Teeth                                       | .... | .... | .... | .... | 53,234  |
|       | Temporary Teeth                                       | .... | .... | .... | .... | 21,204  |
|       | Total                                                 | .... | .... | .... | .... | 74,438  |
| <hr/> |                                                       |      |      |      |      |         |
| (8)   | Number of teeth filled—                               |      |      |      |      |         |
|       | Permanent Teeth                                       | .... | .... | .... | .... | 47,400  |
|       | Temporary Teeth                                       | .... | .... | .... | .... | 19,688  |
|       | Total                                                 | .... | .... | .... | .... | 67,088  |
| <hr/> |                                                       |      |      |      |      |         |
| (9)   | Extractions—                                          |      |      |      |      |         |
|       | Permanent Teeth                                       | .... | .... | .... | .... | 10,262  |
|       | Temporary Teeth                                       | .... | .... | .... | .... | 46,093  |
|       | Total                                                 | .... | .... | .... | .... | 56,355  |
| <hr/> |                                                       |      |      |      |      |         |
| (10)  | Administration of general anaesthetics for extraction | .... |      |      |      | 23,780  |
| <hr/> |                                                       |      |      |      |      |         |
| (11)  | Orthodontics :                                        |      |      |      |      |         |
|       | (a) Cases commenced during the year                   | .... | .... | .... | .... | 2,135   |
|       | (b) Cases carried forward from previous year          | .... | .... | .... | .... | 1,528   |
|       | (c) Cases completed during the year                   | .... | .... | .... | .... | 944     |
|       | (d) Cases discontinued during the year                | .... | .... | .... | .... | 407     |
|       | (e) Pupils treated with appliances                    | .... | .... | .... | .... | 2,561   |
|       | (f) Removable appliances fitted                       | .... | .... | .... | .... | 1,630   |
|       | (g) Fixed appliances fitted                           | .... | .... | .... | .... | 82      |
|       | (h) Total attendances                                 | .... | .... | .... | .... | 16,788  |
| (12)  | Number of pupils supplied with artificial dentures    | .... | .... |      |      | 280     |
| <hr/> |                                                       |      |      |      |      |         |
| (13)  | Other operations—                                     |      |      |      |      |         |
|       | Permanent Teeth                                       | .... | .... | .... | .... | 28,684  |
|       | Temporary Teeth                                       | .... | .... | .... | .... | 12,535  |
|       | Total                                                 | .... | .... | .... | .... | *41,219 |
| <hr/> |                                                       |      |      |      |      |         |

\* including 2,481 operations carried out by oral hygienists.

# APPENDIX B

Table 1(a)—B.C.G. Vaccination of School Children—1956

| Division         | Number of children offered vaccinations (a) | Number Accepting (b) | % Acceptance rate (c) | Positive Reactors at preliminary test |       | Number of children receiving B.C.G. vaccination (f) | Cases of post-vaccinal complications (g) |
|------------------|---------------------------------------------|----------------------|-----------------------|---------------------------------------|-------|-----------------------------------------------------|------------------------------------------|
|                  |                                             |                      |                       | Number (d)                            | % (e) |                                                     |                                          |
| North East Essex | 923                                         | 582                  | 63.0                  | 142                                   | 24.4  | 434                                                 | —                                        |
| Mid Essex        | 1,003                                       | 706                  | 70.4                  | 248                                   | 35.1  | 431                                                 | —                                        |
| South East Essex | 1,349                                       | 557                  | 41.3                  | 90                                    | 16.2  | 454                                                 | —                                        |
| South Essex      | 3,352                                       | 1,566                | 46.7                  | 239                                   | 15.3  | 1,308                                               | —                                        |
| Forest           | 2,412                                       | 1,470                | 60.9                  | 173                                   | 11.8  | 1,286                                               | —                                        |
| Romford          | 1,418                                       | 605                  | 42.7                  | 59                                    | 9.8   | 488                                                 | —                                        |
| Barking          | 1,126                                       | 751                  | 66.7                  | 97                                    | 12.9  | 654                                                 | —                                        |
| Dagenham         | 1,546                                       | 704                  | 45.5                  | 77                                    | 10.9  | 594                                                 | —                                        |
| Ilford           | 2,952                                       | 1,357                | 46.0                  | 158                                   | 11.6  | 1,157                                               | —                                        |
| Leyton           | 1,257                                       | 387                  | 30.8                  | 67                                    | 17.3  | 320                                                 | —                                        |
| Walthamstow      | 2,074                                       | 1,251                | 60.3                  | 178                                   | 14.2  | 1,057                                               | —                                        |
| TOTAL            | 19,412                                      | 9,936                | 51.2                  | 1,528                                 | 15.4  | 8,183*                                              | —                                        |

\* i.e. 97.3% of negative reactors.

Table 1 (b).—Some Statistics concerning the Epidemiology of Tuberculosis in Essex, 1956

| Division         | Percentage of School entrants found to be tuberculin positive | Percentage of children found to be positive on tuberculin testing prior to B.C.G. vaccination at 13 years | No. of Notifications of Tuberculosis |                 |             |                 |             |                 | Incidence of tuberculosis per 1000 school children |
|------------------|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------|-------------|-----------------|-------------|-----------------|----------------------------------------------------|
|                  |                                                               |                                                                                                           | 5—9 yrs.                             |                 | 10—14 yrs.  |                 | 15—19 yrs.  |                 |                                                    |
|                  |                                                               |                                                                                                           | Respiratory                          | Non-Respiratory | Respiratory | Non-Respiratory | Respiratory | Non-Respiratory |                                                    |
| North East Essex | —                                                             | 24.4                                                                                                      | 1                                    | 4               | 0           | 4               | 4           | 3               | 0.35                                               |
| Mid Essex        | —                                                             | 35.1                                                                                                      | 2                                    | 0               | 1           | 1               | 7           | 1               | 0.1                                                |
| South East Essex | —                                                             | 16.2                                                                                                      | 1                                    | 1               | 4           | 1               | 5           | 1               | 0.4                                                |
| South Essex      | —                                                             | 15.3                                                                                                      | 1                                    | 6               | 5           | 4               | 18          | 0               | 0.4                                                |
| Forest           | 1.6                                                           | 11.8                                                                                                      | 3                                    | 1               | 6           | 0               | 10          | 2               | 0.3                                                |
| Romford          | —                                                             | 9.8                                                                                                       | 3                                    | 1               | 2           | 0               | 5           | 0               | 0.3                                                |
| Barking          | —                                                             | 12.9                                                                                                      | 2                                    | 0               | 1           | 0               | 7           | 0               | 0.2                                                |
| Dagenham         | —                                                             | 10.9                                                                                                      | 3                                    | 0               | 3           | 0               | 9           | 1               | 0.3                                                |
| Ilford           | —                                                             | 11.6                                                                                                      | 1                                    | 1               | 3           | 2               | 16          | 3               | 0.3                                                |
| Leyton           | —                                                             | 17.3                                                                                                      | 1                                    | 0               | 1           | 1               | 4           | 0               | 0.2                                                |
| Walthamstow      | —                                                             | 14.2                                                                                                      | 0                                    | 1               | 0           | 1               | 3           | 0               | 0.1                                                |
|                  |                                                               |                                                                                                           | 18                                   | 15              | 26          | 14              | 88          | 11              |                                                    |
|                  |                                                               |                                                                                                           | 33                                   |                 | 40          |                 | 99          |                 |                                                    |

Table 2.—Tonsillectomy Rates—1956

| <i>Age Group</i> | <i>Sex</i> | <i>Number Inspected</i> | <i>Number found to have undergone Tonsillectomy</i> | <i>Percentage found to have undergone Tonsillectomy</i> |
|------------------|------------|-------------------------|-----------------------------------------------------|---------------------------------------------------------|
| 5 years          | Boys       | 13,235                  | 927                                                 | } 6.6                                                   |
|                  | Girls      | 12,698                  | 789                                                 |                                                         |
| 10-12 + years    | Boys       | 14,057                  | 2,532                                               | } 17.4                                                  |
|                  | Girls      | 14,013                  | 2,362                                               |                                                         |
| 14 years         | Boys       | 7,792                   | 1,357                                               | } 16.4                                                  |
|                  | Girls      | 7,761                   | 1,193                                               |                                                         |

Table 3.—Tonsillectomy Rates in Divisions—1956

| <i>Division</i>       | <i>No. of School<br/>Entrants Examined</i> | <i>No. of children<br/>who have had<br/>tonsillectomy</i> | <i>%</i> | <i>No. of children<br/>aged 10-12 and<br/>14 years examined</i> | <i>No. of School<br/>Entrants Examined</i> | <i>%</i> |
|-----------------------|--------------------------------------------|-----------------------------------------------------------|----------|-----------------------------------------------------------------|--------------------------------------------|----------|
| North East Essex .... | 2,618                                      | 191                                                       | 7.2      | 4,563                                                           | 654                                        | 14.3     |
| Mid-Essex ....        | 3,139                                      | 21                                                        | 0.6      | 3,957                                                           | 50                                         | 1.2      |
| South-East Essex .... | 2,381                                      | 118                                                       | 5.1      | 2,191                                                           | 180                                        | 8.2      |
| South Essex ....      | 3,873                                      | 410                                                       | 10.6     | 6,125                                                           | 1,495                                      | 24.4     |
| Forest ....           | 4,152                                      | 228                                                       | 5.5      | 5,371                                                           | 960                                        | 17.6     |
| Romford ....          | 2,102                                      | 138                                                       | 6.5      | 3,185                                                           | 652                                        | 20.4     |
| Barking ....          | 1,141                                      | 95                                                        | 8.3      | 2,077                                                           | 534                                        | 25.6     |
| Dagenham ....         | 1,853                                      | 106                                                       | 5.7      | 3,967                                                           | 362                                        | 9.1      |
| Ilford ....           | 2,382                                      | 290                                                       | 12.1     | 4,259                                                           | 1,065                                      | 25.0     |
| Leyton ....           | 967                                        | 59                                                        | 6.1      | 4,270                                                           | 821                                        | 19.2     |
| Walthamstow ....      | 1,025                                      | 59                                                        | 5.7      | 3,557                                                           | 671                                        | 18.9     |

Table 4.—Child Guidance Service—Statistical Summary

|                                                     | North-East<br>Essex Col-<br>chester Clinic | Mid-Essex<br>Chelmsford<br>Clinic | South Essex<br>Grays<br>Clinic | Ilford<br>Clinic | Walthamstow<br>Clinic | Totals |      |
|-----------------------------------------------------|--------------------------------------------|-----------------------------------|--------------------------------|------------------|-----------------------|--------|------|
|                                                     |                                            |                                   |                                |                  |                       | 1956   | 1955 |
| Children referred to<br>Clinic ....                 | 172                                        | 262                               | 165                            | 189              | 303                   | 1,091  | 924  |
| Children diagnosed ....                             | 107                                        | 190                               | 90                             | 142              | 195                   | 724    | 583  |
| Children treated or<br>under treatment ....         | 74                                         | 154                               | 90                             | 163              | 352                   | 833    | 728  |
| Children discharged—<br>(a) treatment complete      | 41                                         | 80                                | 5                              | 70               | 110                   | 306    | 395  |
| (b) other reasons ....                              | 76                                         | 155                               | 132                            | 101              | 136                   | 600    | 642  |
| Waiting List—<br>Children awaiting<br>diagnosis.... | 40                                         | 97                                | 69                             | 61               | 113                   | 380    | 475  |
| Children diagnosed<br>awaiting treatment            | 33                                         | 3                                 | 17                             | 50               | 2                     | 105    | 77   |

Table 5.—Summary of Handicapped Pupils

| Category                | Newly placed<br>in special<br>schools or<br>homes | Newly assessed<br>as needing special<br>educational<br>treatment at<br>special schools or<br>in Boarding Homes | Number attending<br>special schools |                    | Attending<br>assisted<br>schools | Number<br>boarded<br>in homes | Number<br>remaining<br>unplaced |
|-------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------|----------------------------------|-------------------------------|---------------------------------|
|                         |                                                   |                                                                                                                | Day<br>Pupils                       | Boarding<br>Pupils |                                  |                               |                                 |
| Blind                   | 6                                                 | 10                                                                                                             | —                                   | 48                 | —                                | —                             | 14                              |
| Partially sighted       | 10                                                | 12                                                                                                             | 28                                  | 35                 | —                                | —                             | 9                               |
| Deaf                    | 8                                                 | 7                                                                                                              | 47                                  | 59                 | 6                                | —                             | 4                               |
| Partially deaf          | 11                                                | 16                                                                                                             | 51                                  | 24                 | 2                                | —                             | 9                               |
| Delicate                | 202                                               | 235                                                                                                            | 228                                 | 101                | 2                                | 7                             | 45                              |
| Physically Handicapped  | 50                                                | 46                                                                                                             | 192                                 | 66                 | 15                               | 1                             | 24                              |
| Educationally subnormal | 242                                               | 348                                                                                                            | 715                                 | 252                | 23                               | —                             | 316                             |
| Maladjusted             | 83                                                | 96                                                                                                             | 1                                   | 114                | 84                               | 22                            | 42                              |
| Epileptic               | 9                                                 | 12                                                                                                             | 2                                   | 30                 | —                                | —                             | 7                               |
| Speech defect           | 3                                                 | 3                                                                                                              | —                                   | 3                  | —                                | —                             | —                               |
|                         | 624                                               | 785                                                                                                            | 1,264                               | 732                | 132                              | 30                            | 470                             |

Table 6(a).—Special School placement of Deaf and Partially Deaf Children

|      | No. of children newly<br>assessed as requiring<br>special education at<br>special school |                | No. of children attending special schools |             |                |             |
|------|------------------------------------------------------------------------------------------|----------------|-------------------------------------------|-------------|----------------|-------------|
|      |                                                                                          |                | Deaf                                      |             | Partially Deaf |             |
|      | Deaf                                                                                     | Partially Deaf | Day                                       | Residential | Day            | Residential |
| 1950 | 16                                                                                       | 14             | 31                                        | 49          | 34             | 12          |
| 1951 | 23                                                                                       | 8              | 45                                        | 66          | 27             | 16          |
| 1952 | 18                                                                                       | 12             | 42                                        | 67          | 34             | 20          |
| 1953 | 10                                                                                       | 10             | 43                                        | 68          | 30             | 32          |
| 1954 | 5                                                                                        | 14             | 54                                        | 66          | 39             | 30          |
| 1955 | 8                                                                                        | 9              | 46                                        | 61          | 48             | 32          |
| 1956 | 7                                                                                        | 16             | 47                                        | 59          | 51             | 24          |

Table 6(b).—Survey of Children with Defective Hearing

|                                                                         | N. East<br>Essex | Mid<br>Essex | S. East<br>Essex | South<br>Essex | Forest | Romford | Dagen-<br>ham | Barking | Ilford | Leyton  | W'stow | Totals |
|-------------------------------------------------------------------------|------------------|--------------|------------------|----------------|--------|---------|---------------|---------|--------|---------|--------|--------|
| <i>School Children</i>                                                  |                  |              |                  |                |        |         |               |         |        |         |        |        |
| Children with defective hearing<br>attending ordinary schools :         |                  |              |                  |                |        |         |               |         |        |         |        |        |
| (a) Requiring only special<br>placing                                   | 45               | —            | 63               | 112            | 199    | 92      | 15            | 11      | 12     | 114     | 93     | 714    |
| (b) Using hearing aids                                                  | 12               | 1            | 5                | 15             | 17     | —       | 1             | 6       | 13     | 6       | 6      | 82     |
| Children receiving education in<br>special school for partially<br>deaf | 6                | 5            | 8                | 3              | 15     | 11      | 3             | 7       | 9      | 4       | }      | 189    |
| Children receiving education in<br>special school for deaf              | 17               | 13           | 4                | 21             | 14     | 6       | 13            | 6       | 11     | 6       | }      |        |
| <i>Pre-School Children</i>                                              |                  |              |                  |                |        |         |               |         |        |         |        |        |
| Known to be deaf or partially<br>deaf                                   | 1                | 1            | 4                | 4              | 1      | 1       | 7             | 1       | 4      | 1       | —      | 25     |
| Number of these in need of<br>auditory training                         | —                | —            | 1                | 3              | —      | 1       | n.y.kn.       | n.y.kn. | 3      | n.y.kn. | —      | 8      |

Table 7.—Survey of Children with Cerebral Palsy

|                                                                                          | North-East Essex | Mid-Essex | South-East Essex | South Essex | Forest | Romford | Dagenham* | Barking | Ilford | Leyton | Walthamstow | Total |
|------------------------------------------------------------------------------------------|------------------|-----------|------------------|-------------|--------|---------|-----------|---------|--------|--------|-------------|-------|
| No. of children with cerebral palsy on register of handicapped pupils :                  |                  |           |                  |             |        |         |           |         |        |        |             |       |
| Of school age                                                                            | 11               | 11        | 9                | 22          | 24     | 10      | 13        | 15      | 29     | 6      | 17          | 167   |
| Of pre-school age                                                                        | 1                | —         | 1                | 2           | 16     | 1       | 3         | 2       | 1      | 1      | 1           | 29    |
| <i>Re school children :</i>                                                              |                  |           |                  |             |        |         |           |         |        |        |             |       |
| Incidence per 1,000 children                                                             | 0.4              | 0.35      | 0.4              | 0.5         | 0.7    | 0.5     | 0.6       | 1.2     | 1.2    | 0.35   | 0.8         | 0.6   |
| No. attending ordinary schools                                                           | 4                | 1         | 2                | 5           | 16     | 1       | —         | 6       | 11     | —      | 2           | 49    |
| No. attending :                                                                          |                  |           |                  |             |        |         |           |         |        |        |             |       |
| Day special units for cerebral palsied children                                          | —                | —         | —                | 4           | 3      | 3       | 1         | —       | 7      | 4      | 3           | 25    |
| Other day special schools                                                                | —                | —         | 1                | 7           | 1      | 5       | 10        | 7       | 11     | —      | 7           | 49    |
| Residential schools                                                                      | 5                | 4         | 3                | 3           | 4      | 1       | 1         | 2       | —      | —      | —           | 23    |
| No. receiving home tuition                                                               | 2                | 2         | 3                | —           | —      | —       | 1         | —       | —      | —      | 2           | 10    |
| No. reported under Section 57(3)                                                         | —                | 4         | —                | 2           | —      | —       | —         | —       | —      | 2      | 3           | 11    |
| No. of children above suitably placed or awaiting placement                              | all              | all       | 4/7              | 19/20       | all    | all     | —         | 13/15   | all    | all    | 13/14       | —     |
| No. of children above who would benefit from a special day unit if not already attending | —                | —         | 3                | 1           | —      | —       | —         | —       | —      | —      | —           | 4     |
| <i>Re pre-school children :</i>                                                          |                  |           |                  |             |        |         |           |         |        |        |             |       |
| No. now receiving special educational treatment                                          | —                | —         | —                | —           | —      | —       | —         | —       | —      | 1      | —           | 1     |
| No. who could benefit from attendance at day special unit if not already attending one   | —                | —         | 1                | 2           | —      | 1       | 1         | —       | —      | —      | 1           | 6     |

(\* Provisional figures)

Table 8.—Survey of Children with Epilepsy

|                                                             | North-East Essex | Mid-Essex | South-East Essex | South Essex | Forest | Romford | Dagenham* | Barking | Ilford | Leyton | Walthamstow | Total |
|-------------------------------------------------------------|------------------|-----------|------------------|-------------|--------|---------|-----------|---------|--------|--------|-------------|-------|
| No. of children of school age on handicapped pupil register | 23               | 6         | 10               | 16          | 21     | 8       | 10        | 5       | 34     | 48     | 33          | 214   |
| Incidence per 1,000 school children                         | 1.0              | 0.2       | 0.5              | 0.4         | 0.6    | 0.4     | 0.5       | 0.4     | 1.4    | 3.1    | 1.7         | —     |
| No. of children in ordinary schools                         | 15               | 4         | 3                | 8           | 18     | 5       | 4         | 2       | 20     | 44     | 24          | 147   |
| No. of children in special schools for epileptic children   | 8                | 1         | 5                | 5           | 3      | 1       | 2         | —       | 2      | 3      | 2           | 32    |
| No. of children in other special schools                    | —                | —         | 2                | —           | —      | 1       | 4         | 2       | 12     | 1      | 5           | 27    |
| No. undergoing medical treatment at home or in hospital     | —                | 1         | —                | 3           | —      | 1       | —         | 1       | —      | —      | 2           | 8     |
| No. of pre-school children known to have epilepsy           | 5                | —         | —                | —           | 1      | —       | 1         | 4       | 5      | 4      | 2           | 22    |

(\* Provisional figures)

## APPENDIX C

### Minor Ailment Clinics

#### NORTH-EAST ESSEX DIVISION :

|                                                                                   |                                         |
|-----------------------------------------------------------------------------------|-----------------------------------------|
| School Clinic, Trinity Street, Colchester ..                                      | Mondays to Fridays p.m.                 |
| Essex County Health Services Clinic, 38<br>Main Road, Harwich ....                | Tuesdays and Fridays a.m.               |
| Essex County Health Services Clinic, Col-<br>chester Road, Halstead ....          | Wednesdays a.m.                         |
| Sible Hedingham Secondary School, Sible<br>Hedingham ....                         | Thursdays a.m. (during school<br>term). |
| Essex County Health Services Clinic, 31<br>Skelmersdale Road, Clacton-on-Sea .... | Mondays p.m.                            |
| New Church Schoolroom, Brightlingsea ..                                           | Wednesdays<br>p.m.                      |
| Great Bentley Village Hall, Gt. Bentley ..                                        | 4th Friday<br>p.m.                      |
|                                                                                   | } In conjunction<br>with C.W.C.s        |

#### MID-ESSEX DIVISION :

|                                                                             |                                      |
|-----------------------------------------------------------------------------|--------------------------------------|
| Essex County Health Services Clinic, Cog-<br>geshall Road, Braintree ....   | Tuesdays 10.0 a.m.                   |
| Essex County Health Services Clinic,<br>Crouch Road, Burnham-on-Crouch .... | 2nd Monday 10.0 a.m.                 |
| Essex County Health Services Clinic, Coval<br>Lane, Chelmsford ....         | Every Monday 9.30 a.m.               |
| Essex County Health Services Clinic,<br>Wantz Chase, Maldon ....            | 1st, 3rd and 5th Friday 10.0 a.m.    |
| Congregational Church Hall, Ongar ....                                      | 2nd and 4th Thursday 2.0 p.m.        |
| Essex County Health Services Clinic, 69<br>High Street, Saffron Walden .... | Fridays 10.0 a.m.                    |
| Central Hall, Stanstead ....                                                | 2nd Thursday 9.30 a.m.               |
| Essex County Health Services Clinic,<br>Guithavon Street, Witham ....       | 1st and 3rd Thursday 9.30 a.m.       |
| Essex County Health Services Clinic, 58<br>New Street, Dunmow ....          | 2nd, 4th and 5th Monday 10.0<br>a.m. |

#### SOUTH-EAST ESSEX DIVISION :

|                                                             |              |
|-------------------------------------------------------------|--------------|
| Essex County Health Services Clinic, Great<br>Wakering .... | Fridays a.m. |
|-------------------------------------------------------------|--------------|

SOUTH-EAST ESSEX DIVISION—*Continued.*

|                                                                                    |                      |
|------------------------------------------------------------------------------------|----------------------|
| Essex County Health Services Clinic,<br>Rocheway, Rochford ....                    | Tuesdays a.m.        |
| Essex County Health Services Clinic, East-<br>wood Road, Rayleigh ....             | Tuesdays a.m.        |
| Essex County Health Services, Clinic Ken-<br>neth Road, Thundersley ....           | Thursdays            |
| Essex County Health Services Clinic,<br>Nevedon Road, Wickford ....                | Mondays a.m.         |
| Essex County Health Services Clinic, High<br>Road, Pitsea ....                     | Mondays a.m.         |
| Essex County Health Services, Clinic<br>Florence Road, Laindon ....                | Wednesdays a.m.      |
| Essex County Health Services Clinic, Lain-<br>don Road, Billericay ....            | Thursdays a.m.       |
| Essex County Health Services Clinic, Fur-<br>therwick Road, Canvey Island ....     | Mondays a.m.         |
| Essex County Health Services Clinic, High<br>Road, South Benfleet ....             | Thursdays 10.45 a.m. |
| Essex County Health Services Clinic, Cray-<br>lands, Timberlog Lane, Basildon .... | Tuesdays a.m.        |
| Essex County Health Services Clinic, Lon-<br>don Road, Hadleigh ....               | 1st Friday a.m.      |

## SOUTH ESSEX DIVISION :

|                                                                                 |                                          |
|---------------------------------------------------------------------------------|------------------------------------------|
| Essex County Health Services Clinic, 39<br>Queen's Road, Brentwood ....         | Wednesdays a.m.                          |
| Essex County Health Services Clinic, West-<br>land Avenue, Hornchurch ....      | Tuesdays and Thursdays a.m.              |
| Essex County Health Services Clinic, Abbs<br>Cross Lane, Hornchurch ....        | Thursdays a.m.                           |
| Essex County Health Services Clinic, 61<br>Athelstan Road, Harold Wood ....     | 2nd and 4th Friday only a.m.             |
| Essex County Health Services Clinic, Up-<br>minster Road, Rainham ....          | Thursdays a.m.                           |
| Essex County Health Services Clinic, 230<br>St. Mary's Lane, Upminster ....     | Wednesdays a.m.                          |
| Essex County Health Services Clinic, Glas-<br>son House, High Street, Grays.... | Wednesdays a.m.                          |
| Essex County Health Services Clinic,<br>Newton Road, Tilbury ....               | Mondays a.m. & 2nd & 4th<br>Fridays a.m. |
| St. Margaret's Hall, Corringham Road,<br>Stanford-le-Hope ....                  | Thursdays a.m.                           |
| Village Hall, North Road, South Ocken-<br>don, near Grays ....                  | Mondays a.m.                             |

|                                                                                           |                            |
|-------------------------------------------------------------------------------------------|----------------------------|
| Essex County Health Services Clinic,<br>Stifford Long Lane, Grays ....                    | Thursdays a.m.             |
| Essex County Health Services Clinic, River<br>View, Chadwell St. Mary, Grays ....         | 2nd and 4th Tuesdays a.m.  |
| Aveley Health Centre, Darenth Lane,<br>South Ockendon ....                                | Fridays a.m.               |
| Essex County Health Services Clinic,<br>South End Road, South Hornchurch,<br>Rainham .... | Mondays and Thursdays a.m. |
| Essex County Health Services Clinic, Hall<br>Road, Aveley ....                            | Fridays a.m.               |
| Essex County Health Services Clinic, Lon-<br>don Road, Purfleet ....                      | 1st Wednesdays p.m.        |
| Three Arch Bridge Health Services Clinic,<br>Cherry Avenue, Brentwood ....                | Tuesdays a.m.              |

## FOREST DIVISION :

|                                                                                             |                                     |
|---------------------------------------------------------------------------------------------|-------------------------------------|
| Essex County Health Services Clinic, Man-<br>ford Way, Chigwell ....                        | Thursdays a.m.                      |
| Essex County Health Services Clinic,<br>Hatch Lane, Chingford ....                          | 1st, 2nd and 4th Monday p.m.        |
| Essex County Health Services Clinic, Mar-<br>mion Avenue, Chingford ....                    | Mondays a.m.                        |
| Essex County Health Services Clinic, 15<br>Regent Road, Epping ....                         | 1st and 3rd Monday a.m.             |
| Nuffield House, The Stowe, Harlow ....                                                      | Alternate Fridays a.m.              |
| Essex County Health Services Clinic,<br>Loughton Hall, Rectory Lane, Loughton               | Thursdays a.m.                      |
| Essex County Health Services Clinic, The<br>Cedars, Sewardstone Road, Waltham<br>Abbey .... | 2nd and 4th Tuesday 9.30—11<br>a.m. |

## ROMFORD :

|                                                                        |                |
|------------------------------------------------------------------------|----------------|
| Essex County Health Services Clinic, Hulse<br>Avenue, Collier Row .... | Mondays a.m.   |
| Parklands School ....                                                  | Thursdays a.m. |
| Hilldene School ....                                                   | Tuesdays a.m.  |
| Essex County Health Services Clinic,<br>Marks Road ....                | Saturdays a.m. |
| Harold Hill Health Centre, Gooshays<br>Drive, Harold Hill ....         | Mondays a.m.   |

## BARKING :

|                                                                              |              |
|------------------------------------------------------------------------------|--------------|
| Essex County Health Services Clinic,<br>Vicarage Drive, Ripple Road, Barking | Each morning |
|------------------------------------------------------------------------------|--------------|

BARKING—*continued*.

|                                                                       |              |
|-----------------------------------------------------------------------|--------------|
| Essex County Health Services Clinic,<br>Porters Avenue, Dagenham .... | Each morning |
| Essex County Health Services Clinic,<br>Woodward Road, Dagenham ....  | Each morning |
| Essex County Health Services Clinic,<br>Upney Lane, Barking ....      | Each morning |

## DAGENHAM :

|                                                                               |                                             |
|-------------------------------------------------------------------------------|---------------------------------------------|
| Five Elms School ....                                                         | Mondays p.m. and Fridays a.m.               |
| Essex County Health Services Clinic,<br>Becontree Avenue ....                 | Mondays and Thursdays a.m.                  |
| Hunters Hall School ....                                                      | Tuesdays 9.30 a.m.                          |
| John Perry School ....                                                        | Tuesdays 11 a.m.                            |
| Essex County Health Services Clinic, Bal-<br>lards Road ....                  | Wednesdays p.m.                             |
| Essex County Health Services Clinic, Ash-<br>ton Gardens, Chadwell Heath .... | Tuesdays a.m.                               |
| Essex County Health Services Clinic, Ford<br>Road ....                        | Mondays a.m. and p.m. and<br>Thursdays p.m. |
| Kings Wood School, Harbourn Road,<br>Hainault ....                            | Mondays 9.30 a.m. 1st and 3rd<br>in month   |

## ILFORD :

|                                                                       |                             |
|-----------------------------------------------------------------------|-----------------------------|
| Newbury Hall, Perryman's Farm Road,<br>Newbury Park ....              | Tuesdays and Fridays a.m.   |
| Essex County Health Services Clinic,<br>Goodmayes Lane, Goodmayes.... | Wednesdays and Fridays a.m. |

## LEYTON :

|                                                                                |                                 |
|--------------------------------------------------------------------------------|---------------------------------|
| Essex County Health Services Clinic,<br>Granleigh Road, Leytonstone, E.11 .... | Daily a.m., including Saturdays |
| Essex County Health Services Clinic,<br>Leyton Green Road, Leyton ....         | Daily a.m.                      |
| Essex County Health Services Clinic,<br>Dawlish Road, Leyton ....              | Daily a.m., including Saturdays |

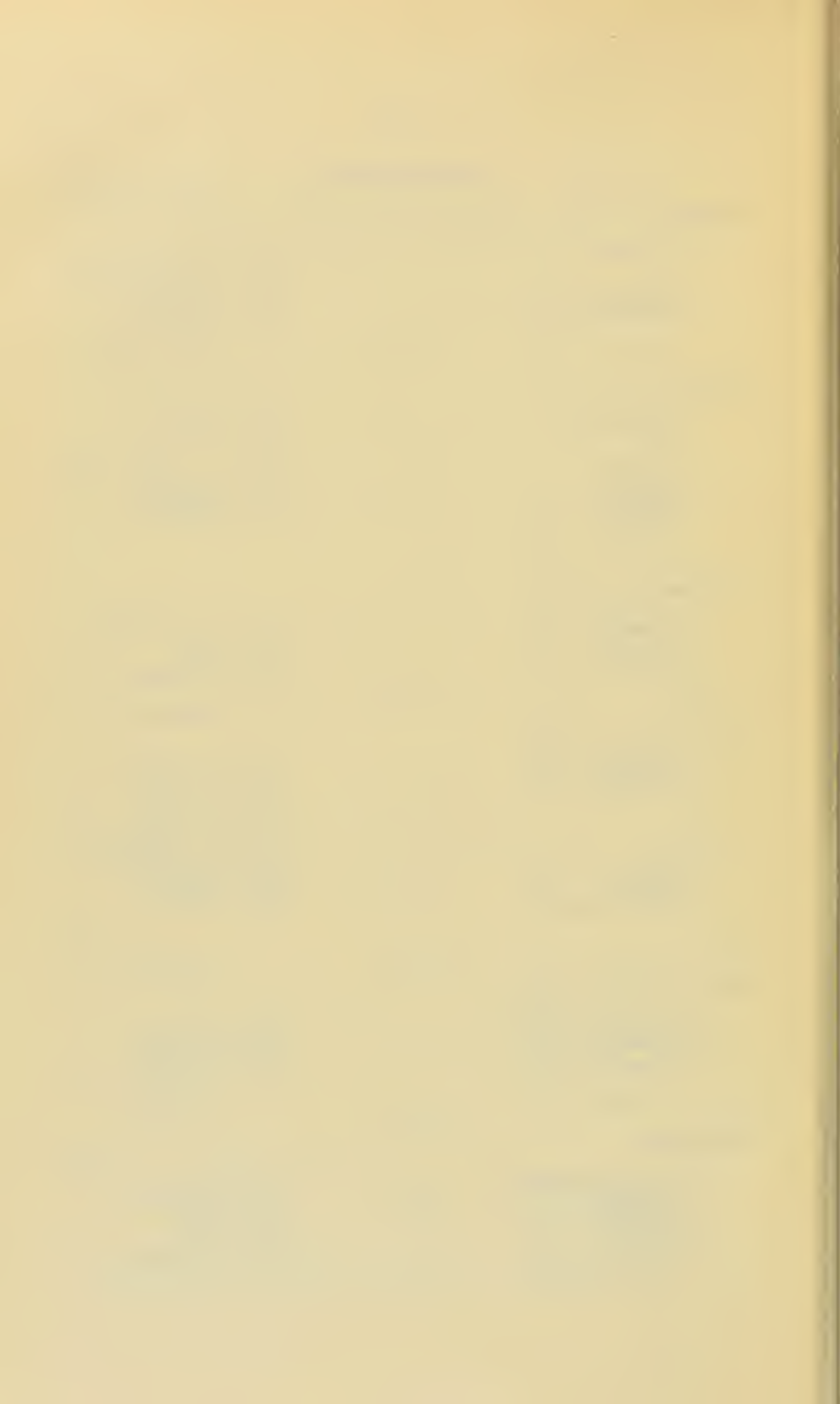
## WALTHAMSTOW :

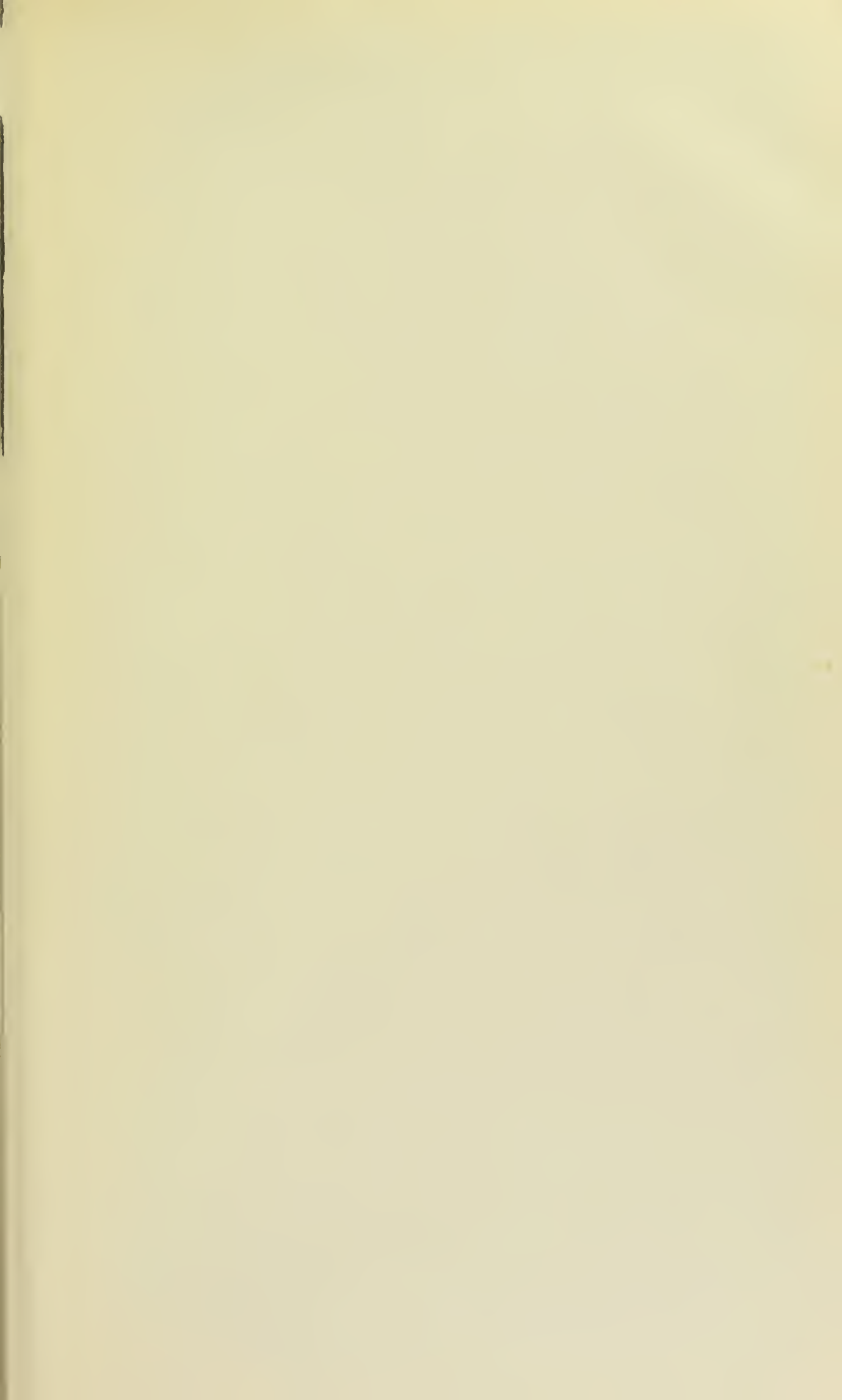
|                                                                            |                                                    |
|----------------------------------------------------------------------------|----------------------------------------------------|
| Town Hall ....                                                             | Mondays, Wednesdays, Fridays<br>and Saturdays a.m. |
| Essex County Health Services Clinic,<br>Silverdale Road, Highams Park .... | Tuesdays a.m.                                      |
| Essex County Health Services Clinic, Low<br>Hall Lane, Markhouse Road .... | Mondays and Thursdays a.m.                         |

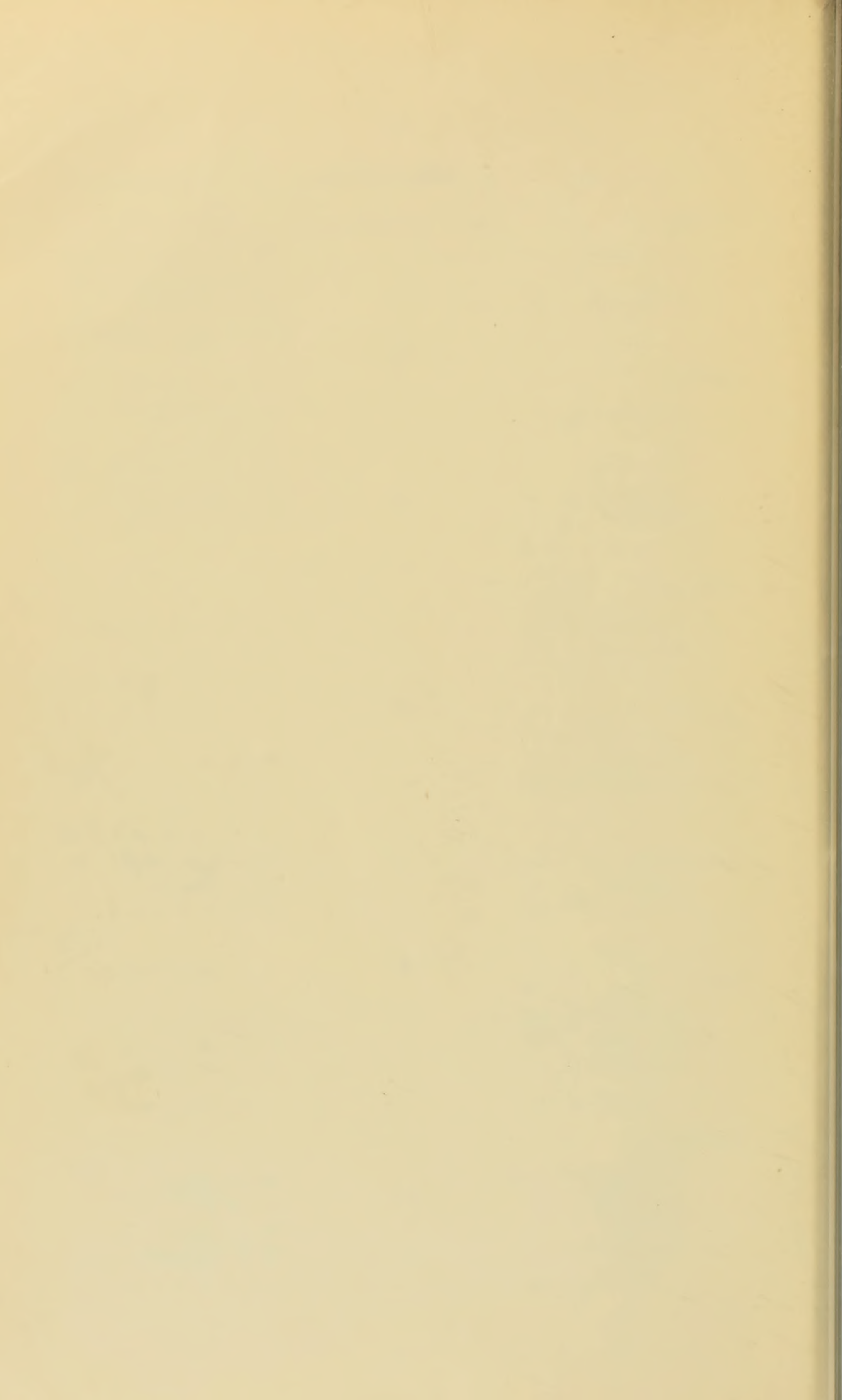
## Specialist Clinics

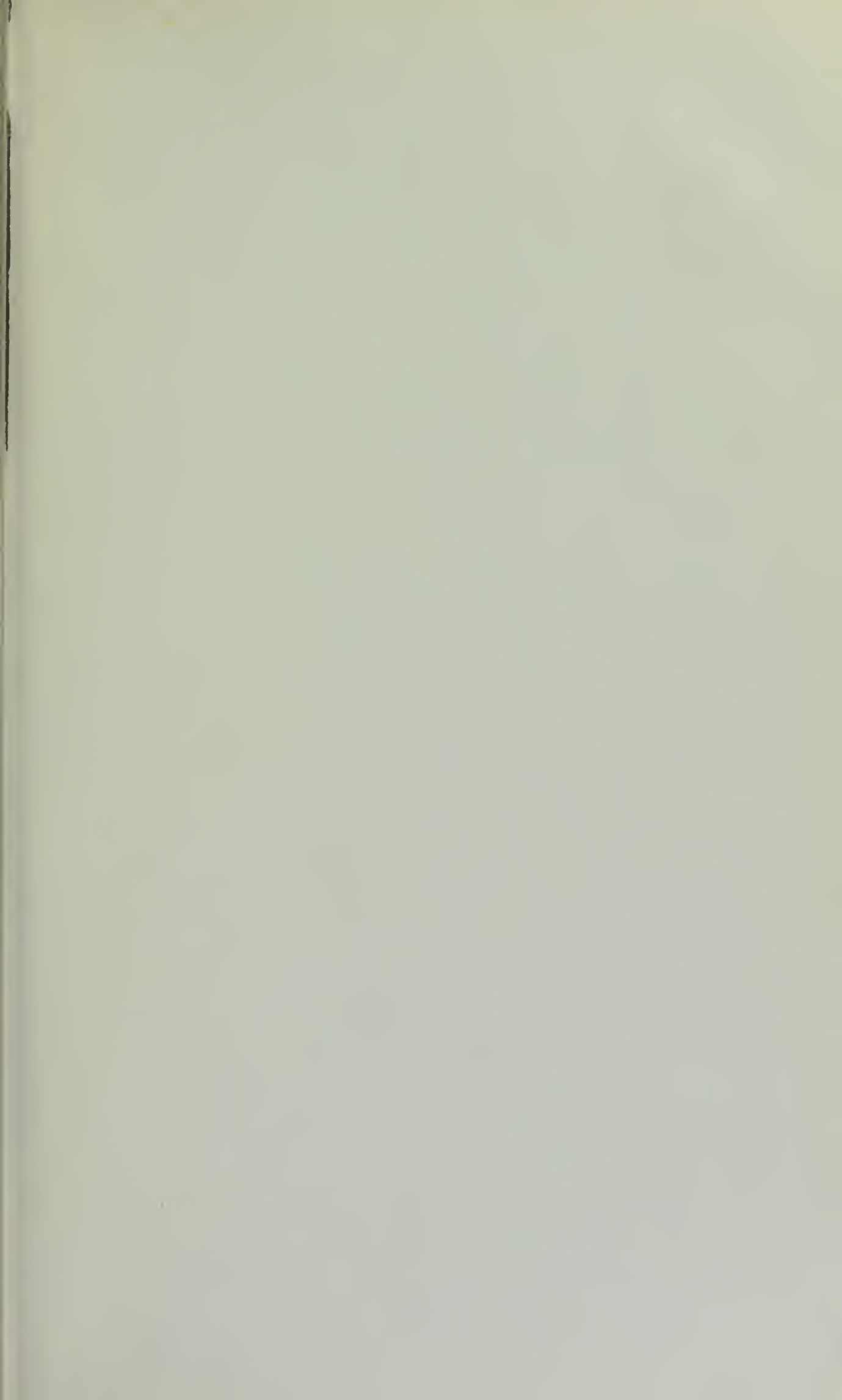
| <i>Type of Clinic</i> | <i>No. of Sessions Monthly</i> |      |                  |      | <i>Name of Specialist</i>                                                                                                                                |
|-----------------------|--------------------------------|------|------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <i>North-East</i>     |                                |      |                  |      |                                                                                                                                                          |
| Ophthalmic            | ....                           | .... | 22               | .... | Dr. R. W. Cushing<br>Dr. H. S. Sweet                                                                                                                     |
| Orthopædic            | ....                           | .... | 1 $\frac{2}{3}$  | .... | Mr. D. M. Dunn                                                                                                                                           |
| Physical Medicine     | ....                           |      | 16               | .... | Dr. K. W. Nichols Palmer                                                                                                                                 |
| Ear, Nose & Throat    | ....                           |      | 1                | .... | Mr. J. M. Green                                                                                                                                          |
| <hr/>                 |                                |      |                  |      |                                                                                                                                                          |
| <i>Mid</i>            |                                |      |                  |      |                                                                                                                                                          |
| Ophthalmic            | ....                           | .... | 22               | .... | Dr. A. H. Staples<br>Dr. S. G. Tibbles<br>Dr. J. J. Reilly<br>Dr. H. S. Sweet<br>Dr. J. J. Regal<br>Mr. G. Wright<br>Mr. A. E. Sawdey<br>Dr. G. F. Ensor |
| Orthopædic            | ....                           | .... | 15 $\frac{1}{3}$ | .... | Mr. H. A. H. Harris<br>Mr. D. M. Dunn<br>Mr. R. W. Butler<br>Mr. G. R. Fisk                                                                              |
| <hr/>                 |                                |      |                  |      |                                                                                                                                                          |
| <i>South-East</i>     |                                |      |                  |      |                                                                                                                                                          |
| Ophthalmic            | ....                           | .... | 14 $\frac{1}{3}$ | .... | Dr. G. T. Foster Smith<br>Dr. B. C. Dench                                                                                                                |
| <hr/>                 |                                |      |                  |      |                                                                                                                                                          |
| <i>South</i>          |                                |      |                  |      |                                                                                                                                                          |
| Ophthalmic            | ....                           | .... | 28               | .... | Dr. H. J. Thorne<br>Dr. J. J. Regal<br>Dr. G. R. Bhatia<br>Dr. D. E. Hove<br>Dr. M. Cripps                                                               |
| Orthopædic            | ....                           | .... | 1                | .... | Mr. G. Barclay                                                                                                                                           |
| <hr/>                 |                                |      |                  |      |                                                                                                                                                          |
| <i>Forest</i>         |                                |      |                  |      |                                                                                                                                                          |
| Ophthalmic            | ....                           | .... | 20               | .... | Dr. M. Harley<br>Dr. G. F. Ensor                                                                                                                         |
| Orthopædic            | ....                           | .... | 5 $\frac{1}{2}$  | .... | Mr. H. G. Korvin<br>Mr. G. R. Fisk                                                                                                                       |

| Type of Clinic       |      | No. of Sessions Monthly |    |      | Name of Specialist     |
|----------------------|------|-------------------------|----|------|------------------------|
| Romford              |      |                         |    |      |                        |
| Ophthalmic           | .... | ....                    | 5  | .... | Dr. J. J. Regal        |
|                      |      |                         |    |      | Dr. G. T. Foster Smith |
| Orthopædic           | .... | ....                    | 8  | .... | Mr. G. Barclay         |
|                      |      |                         |    |      | Mr. A. M. A. Moore     |
| <hr/>                |      |                         |    |      |                        |
| Barking              |      |                         |    |      |                        |
| Dermatology          | .... | ....                    | 2  | .... | Dr. P. Deville         |
| E.N.T.               | .... | ....                    | 4  | .... | Miss M. Mason          |
| Ophthalmic           | .... | ....                    | 12 | .... | Dr. R. F. Jamieson     |
| Orthopædic           | .... | ....                    | 2  | .... | Mr. Leon Gillis        |
| Paediatric           | .... | ....                    | 2  | .... | Dr. S. B. Dimson       |
| <hr/>                |      |                         |    |      |                        |
| Dagenham             |      |                         |    |      |                        |
| Orthopædic           | .... | ....                    | 1  | .... | Mr. A. M. A. Moore     |
| Ophthalmic           | .... | ....                    | 8  | .... | Dr. J. Regal           |
|                      |      |                         |    |      | Dr. H. Macfarlane      |
| <hr/>                |      |                         |    |      |                        |
| Ilford               |      |                         |    |      |                        |
| Orthopædic           | .... | ....                    | 7  | .... | Mr. H. A. Korvin       |
| Ophthalmic           | .... | ....                    | 17 | .... | Dr. M. H. Malik        |
|                      |      |                         |    |      | Dr. H. J. Thorne       |
|                      |      |                         |    |      | Dr. M. M. Hughes       |
| Aural                | .... | ....                    | 4  | .... | Miss M. M. Mason       |
| Paediatric           | .... | ....                    | 2  | .... | Dr. A. Russell         |
| Cerebral Palsy Unit  | .... | ....                    | 4  | .... | Dr. D. L. Woolf        |
| <hr/>                |      |                         |    |      |                        |
| Leyton               |      |                         |    |      |                        |
| Ear, Nose and Throat | .... | ....                    | 4  | .... | Mr. C. J. Scott        |
| Ophthalmic           | .... | ....                    | 8  | .... | Dr. Logan Adams        |
| Orthopædic           | .... | ....                    | 1  | .... | Mr. J. M. Oatley       |
| <hr/>                |      |                         |    |      |                        |
| Walthamstow          |      |                         |    |      |                        |
| Ear, Nose and Throat | .... | ....                    | 4  | .... | Mr. F. Clarke          |
| Ophthalmic           | .... | ....                    | 20 | .... | Dr. H. Ho              |
| Paediatric           | .... | ....                    | 2  | .... | Dr. E. Hinden          |
| Orthopædic           | .... | ....                    | 1  | .... | Mr. G. Rigby-Jones     |









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